PRACTICAL ASPECTS OF PSYCHOANALYSIS

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A Handbook for Prospective Patients and Their Advisors

By

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To

THE FUTURE OF THE

NEW YORK PSYCHOANALYTIC INSTITUTE

FOREWORD

AN INTELLIGENT and instructed laity is indispensable for the practice of sound medicine. This book is written to help people recognize sound psychoanalytical procedure when they meet it, and to introduce them to those institutes for the training of psychoanalysts which at present constitute their best protection against charlatans in this field.

In part, therefore, this is a fighting book, in that one of its purposes in clarifying the meaning of psychoanalysis is to exterminate pseudo-analysis by inadequately trained or irresponsible analysts, whether these are found within or without the official psychoanalytic fold.

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INTRODUCTION

Avoidable Misunderstandings

There are four reasons for offering this book to the public: (1) The unobstructed progress of an analysis can be assisted by a sound intellectual understanding between the psychoanalyst, the patient, the patient's family, and the physician who has sent the patient to the psychoanalyst. It is not to be expected that such an intellectual rapport can possibly remove deep-seated emotional obstacles. That is a task for the analysis itself. Nor is it even desirable that frank and open skepticism should be eliminated, such skepticism being both healthy and inevitable. There is, however, so much misunderstanding that is avoidable, both among laymen and in the medical profession, that this handbook is offered to both these groups with

the hope that it will clarify many unnecessary misconceptions.

Alterations in Relationship of Doctor and Patient

(2) At the outset, the introduction of the psychoanalytic method meant no significant alterations in the traditional relationship between the patient and his physician. Gradually, however, certain modifications occurred in this age-old bond; and although these changes have been the necessary results of experience, nonetheless they are often misunderstood. It would seem that a simple explanation of this changed relationship should remove some of the unnecessary and undesirable atmosphere of mystery which shrouds the practice of psychoanalysis.

Help in Selecting a Psychoanalyst

(3) Furthermore, while in all fields of medicine it is lamentably true that the layman has to take his physician's ability largely on faith, and that popular reputation and scientific ability have a relationship that is almost wholly accidental, this is even more true in the field of psychiatry and psychoanalysis. The layman

forms his opinion of a physician's ability chiefly through the legends which grow up about his supposed triumphs or failures, either with particular patients or in the treatment of some special form of disease. In psychiatry, however, not only are the evidences of illness often obscure, but in addition psychiatric patients hide their ills even from their nearest friends and relations. Furthermore, even if they were so inclined they could tell little or nothing of what goes on during their analyses. How then can laymen judge the results of the mysterious treatment of a friend whose troubles they appreciate only vaguely? And how then can they judge the ability of a psychoanalyst from his works? Fortunately, as will be explained below, there are ways of ascertaining at least the training and professional standing of a man who is to be consulted, and so of eliminating some of the more serious mistakes which are made so often in the choice of psychiatric guidance.

The Deluge of Questions

(4) There is hardly a day in the social or professional life of a psychiatrist in which he is

not asked a multitude of questions, such as: "What is psychoanalysis about?" "What's the difference between Jung and Freud?" "Why are there so many schools?" "Why does it last so long?" "Why does it cost so much?" "Why is there so much secrecy about it?" "Isn't it a bit of a fad?" "Isn't it dying out?" "Why does one have to go so often?" "Why must you lie down?" "Doesn't it make you morbidly introspective?" "Do you ever get free from it?" "Do you always fall in love with your analyst?" "Isn't it dangerous?" "Does it ever do anybody any good?" "Why can't you be analyzed by a relative or friend?" "Who comes to analysis anyhow?"

Not all of these questions will be answered in this practical guide-book; but it is hoped that the chapters which follow will clear away the misconceptions which lie behind many of them. It is vitally important that anyone who contemplates an analysis should have some inkling of the differences between that which is truly psychoanalytic and those many abuses which masquerade under its banner.

PRACTICAL ASPECTS OF PSYCHOANALYSIS

CHAPTER I

FREUDIAN PSYCHOANALYSIS

PSYCHOANALYSIS is a specific technique for studying and influencing the distribution and utilization of psychological energy.

The Name

In medicine every well-defined method of treatment or investigation merits its own descriptive name. Because it is important for the public to realize that radiation is different from surgery as a treatment for tumor, it is necessary for the medical profession to have a separate word for each. Without such names confusion arises. In the general field of psychiatry the same simple principle is valid.

Some of the critics of Freudian psychoanalysis have recognized the truth of this by coining special designations for their own methods: as, for instance, the "analytical psychology" of

Jung, the "individual psychology" of Adler, or the "phyloanalysis" of Burrows. It would help still further in the elimination of confusion if Stekel and Rank would likewise use distinguishing terms for their contrasting methods; for it must be obvious that whenever fundamentally dissimilar medical procedures are called by one name, it becomes impossible for either the physician or the layman to judge the value of any one of them. It is to everyone's interest, therefore, to limit the term "psychoanalysis" to a clearly defined technique for dealing with psychiatric and psychological problems.

Dictum of the British Medical Association

After an impartial investigation the British Medical Association came to the same conclusion, and formulated the following definition and general principles: (*British Medical Journal,* Supplement, Appendix 2, June 29, 1929, p. 266, paragraphs 27 and 28.)

"There is in the medical and general public the tendency to use the term 'psychoanalysis' in a very loose and wide sense. This term can legitimately be applied only to the method

evolved by Freud and to the theories derived from the use of this method. A psychoanalyst is therefore a person who uses Freud's technique, and anyone who does not use this technique should not, whatever other method he may employ, be called a psychoanalyst. In accordance with this definition and for the purpose of avoiding confusion, the term 'psychoanalyst' is properly reserved for members of the International Psychoanalytical Association.... (*q.v.* Ch. 9.)

"Much confusion and misunderstanding relative to psychoanalysis has arisen from a failure to recognize and adopt the definition herein indicated. Thus, clearly, criticisms of psychoanalytical theory or practice should be confined to the teaching and methods of those who are psychoanalysts in the true sense of this term. This is not always so, and the Committee has received a number of reports and statements adverse to psychoanalysis as a form of medical treatment which on inquiry are found to be based upon methods put into operation not by psychoanalysts, but by other practitioners who adopt or accept the name but lack the qualifications."

The Domain and the Technical Objectives of Psychoanalysis

A scientific method is comprehensible only when one understands what it attempts to do in relation to some natural phenomenon. Although psychoanalysis is a complex instrument, its subject matter and its aims can be summarized in simple terms, as follows: (1) There are unconscious mental forces. (2) These always play an important role in determining human behavior. (3) Where they play a *dominant* role, such behavior cannot be influenced materially without altering these underlying factors. (4) In order to do this it is first necessary to find out what the unconscious mental forces are. (5) This makes necessary the use of a highly specialized technique, which is designed to overcome certain obstacles to the exposure of unconscious material. (6) This technique is at the same time effective in modifying the influence of the unconscious forces which are brought to light. Such a summary embodies much controversial matter. It will nevertheless be used here as a working hypothesis.

Fundamental Boundaries of its Domain

Psychoanalysis then has as its weapon the uncovering and the modifying of unconscious psychological forces. With a procedure to achieve this purpose, the psychoanalyst attempts to relieve suffering whenever he finds that it is caused predominantly by mental processes which operate within the patient but of which the patient is himself unaware. The psychoanalyst cannot use his method to shield the patient from the accidents of life. Nor can he prevent diseases that are primarily organic in origin. In such situations the most that he can hope to do is to increase the patient's resistance to adversity by lessening the obscure but far-reaching influences of inner emotional storms.

The Historical Expansion of Psychoanalysis

Psychoanalysis began humbly and empirically with the treatment of only one type of outspoken neurosis. Gradually it has extended its domains, sometimes successfully, sometimes with difficulties. Whenever, in science, a new method arises, such expansion and retraction is inevitable. Whether it be a technique of inves-

tigation or of treatment, it is tried out hopefully on all of the old and unsolved problems. Like Leuwenhoek with his microscope, the psychoanalyst has been eagerly curious to examine everything which has come to his hand.

Therapeutically his significance is proving to be greatest where the unconscious forces are most important; and by and large his value is most restricted where purely environmental or bodily factors are more active. Psychoanalysis is applied directly to the investigation of all of the psychoneuroses and to their treatment, to the study of human discontent (i.e., the "masked neurosis" of the so-called normal), to the neurotic disturbances of childhood, and to the frank psychoses (or insanities). In certain of these fields its therapeutic value and its limitations have not been tested sufficiently for any final conclusions. *Therefore a patient should come to a psychoanalyst not asking to be analyzed, but asking whether or not he should be analyzed.*

Psychoanalytic Concept of Mental Health; Various Distinctions Between Normal and Abnormal

In this expansion of the field of psychoanalytic effort there is implicit a strenuous and uncompromising ideal of mental health. The analyst cannot be content with a definition of normality as being that which approximates some vague or shifting social norm. Merely because in a certain environment and under certain circumstances others would feel the same way or do the same thing does not argue that such feeling or conduct is normal. Common colds are illnesses, even though everyone catches colds. Furthermore the sociological and legal contrast between the sane and the insane does not throw light on the problem of normality, since it deals only with the practical differentiation between those people who on the whole can be held responsible for their conduct and those who for any one of several reasons must be safeguarded like children from the consequences of their own impulses.

The Symptomatic Neurosis—Its Evolution Out of the Masked Neurosis

Nor does the analytic concept of the abnormal limit itself to cases so outspoken that the symptoms are obvious to any layman who has an opportunity to observe them. Such cases are set apart as the frankly "symptomatic neuroses": e.g., the blind and purposeless terrors at harmless situations; the tyrannical compulsions to spend one's days in carrying out useless rituals; the pseudo-manifestations of physical ailments where no such ailments exist; or states of pathological rage, fear, or depression, and the like. For centuries disturbances such as these have been recognized as illnesses. It is only in more recent years, however, that the existence of subtler neurotic traits has been appreciated. It is known now that similar tendencies exist in all human beings, but in masked and attenuated forms. Furthermore the study of normal childhood has shown that all children go through repeated episodes in which these latent neurotic tendencies erupt temporarily into full-blown symptomatic activity, and that the manner in which these transient neurotic episodes are resolved in childhood determines

to a large extent both the masked and the outspoken neurotic tendencies of the adult.

Normality Conceived as the Freedom From Masked Neurotic Tendencies—The External Evidences of Such Normality

Therefore, to the analyst, normality means the elimination of the *masked* as well as the *outspoken* neurotic tendencies of the personality. Freedom such as this is manifested in several ways. First, perhaps, is the strength to withstand the pressure of external events; that is, the ability to tolerate uncertainty without generating excessive anxiety or confusion, and the capacity to sustain deprivation and frustration without either blind and excessive anger on the one hand, or paralyzing depression on the other. Secondly, it will be apparent through the relative absence of blindly compulsive activity.

It is health such as this which is the goal of psychoanalytic therapy; and this is achieved in analysis by altering the *distribution* and *utilization* of psychological energy. The equally important study of the *sources* of psychological energy goes beyond the domain of psychoanal-

ysis proper into a realm of organic physiological research—a field of inquiry which is only slowly yielding to the pressure of scientific investigation. In this obscure region the organic investigator and the psychoanalyst work together to discover the relationships which must exist between the varied psychological uses of energy and its varying organic origins.

CHAPTER II

THE EXPERIENCE OF BEING PSYCHOANALYZED

TO a prospective patient psychoanalysis is not a purely theoretical conception; nor is it merely a method of investigating or treating a certain type of illness. It is an experience through which he is about to pass; and it is natural that he should want to have some idea as to what this experience will be like. A detailed preview is neither possible nor even desirable; and only those will seek it who are struggling with an excessive amount of anxiety about the undertaking. Such excessive anxiety as that, since it has its origins in unconscious problems, cannot be set at rest by descriptions of the process of analysis, however reasonable or reassuring. This chapter, therefore, cannot be directed towards the resolution of the neurotic terror with which some patients come to analy-

sis, but only towards allaying the more reasonable diffidence of the rest.

Current Misconceptions

Despite a steadily growing interest and confidence in psychoanalysis, misconceptions persist in the minds even of educated people. It may be believed, for instance, that the patient comes to analysis in an attitude of furtive erotic curiosity, that the analyst asks the patient a great many embarrassing and exciting questions, that the patient falls in love with the psychoanalyst more or less frankly, and that they maintain an atmosphere of self-indulgent emotionalism. In the end the patient may hope to carry away a pearl of analytical wisdom in the form of a written or oral digest of all his most secret problems, together with an outline of guiding principles and directions as to what he should or should not do in the future. It is rare nowadays to find anyone who could not correct one or more of the misconceptions in this total picture. In the minds of most laymen and of many physicians, however, some fragments of it still persist.

Psychoanalysis as an Actual Experience

The realities of psychoanalysis are quite different. Patients usually approach analysis only with hesitation and misgivings, under the stress of their own inner wretchedness, or because of the urgent pressure of family, friends, or physician. Throughout the analysis they encounter an atmosphere of friendly courtesy, coupled with a fairly strict formality and reserve. They find that the psychoanalyst's private life and his personality are exhibited just as little as possible, and that even the most formal social relationship with the psychoanalyst is excluded. Indeed, if the psychoanalyst whom they have chosen to consult has had a prior relationship as friend or advisor, they discover that he will, if he is conscientious, send them to someone who is a total stranger.

Once launched in the work of the analytic session, they find that instead of an affectionate and comforting friendship they do not even hold reasonable human conversations. Usually they lie on a couch with the analyst seated behind them so that he can see them without being seen. Since they do not face him they cannot watch his expression or respond to his

fancied approval or disapproval, or laugh and joke with him about their troubles in order to smooth the path for talking about them. To their surprise they may talk for long periods with scarcely an interruption, whereas at other times they will be checked with insistent comments—comments which may sometimes make them more comfortable, but which, quite as often, may prove to be deeply disturbing.

Furthermore the analysis is found to make formidable demands. It requires at least five and sometimes six sessions each week. These sessions start and stop punctually, and last as precisely as is possible for the fifty or sixty minutes which is agreed upon ahead of time. Patients are usually charged for sessions which they miss; and they soon discover that it is difficult to change the hour of an appointment. They are not encouraged to miss sessions for other obligations, whether pleasant or unpleasant, except when it is absolutely unavoidable. In short, from the very start the analysis turns out to be an exacting, precise and formal taskmaster.

Before long the patient encounters periods of emotional turmoil and distress, or arid days

or weeks in which he cannot see where he is going or what progress he is making, and in which he is overwhelmed by impatience, boredom, resentment, skepticism, and a host of other unpleasant feelings.

That hypothetical individual who comes to analysis because of erotic or morbid curiosity soon finds his shallow motivation exposed under such a regime. His interest wanes, and he does not waste his time or the analyst's for very long before dropping out of the picture. On the other hand, the sincere patient somehow manages to carry on despite the pain, the time, and the expense, through the arid stretches as well as over the occasional mountain tops, through one or even more years of intensive work.

Duration

At this point questions must inevitably arise, such as why it must take so long, why there are no short-cuts, why it goes on day after day for all that time, how one can find things to talk about for so long a period, and in the end what one gains from it all.

Why it must go on and on without interrup-

tion for days, and how it happens that one can "find things to talk about," and what final outcome one may expect, will become clearer, we hope, in the succeeding chapters. Here, however, it is appropriate to discuss the problem of duration.

The Chronic Nature of Neurotic Problems

Unfortunately none of the ills which are subjected to psychoanalytic treatment are acute and passing ailments. Instead they are for the most part chronic illnesses with occasional acute exacerbations. The chronic phases of the illness may often pass for normal; just as the sufferer from tuberculosis may seem to be normal in an interval between attacks or even for years before his infection manifests itself openly. In fact, as Glover pointed out, there is an instructive although superficial analogy between the problems of treatment in the two types of illness. The acute episode in each may be transient; but the physician who at the end of such an episode contents himself with discharging as cured a patient whose illness has once shown signs of "activity" is either careless or unscrupulous.

It is only then that the long march towards lasting health begins. It is totally unreasonable to think that life-long illnesses, be they low-grade chronic infections or masked neurotic traits, can be cured in a short time. One measures the duration of adequate treatment in terms of years and not of months. The so-called psychoanalyst who fails to explain this to his patient before beginning treatment, and who discharges the patient at the end of a few months of apparently successful work without making it clear that the job is only partly done, is doing his patient no service.

The Futile Search for Shorter Analyses

Although many shorter roads have been sought, none have as yet been found. It may be that it is in the very nature of these illnesses that none will ever be found, although on that point one need not be too pessimistic. This search for a shorter road has led to many of the schisms in the psychoanalytic camp. To offer a sick man a shorter road to health is to offer him something for which he yearns. The conscientious psychoanalyst who warns his prospective patient of the probable duration of his

treatment frightens many away. The temptation is great, therefore, to comfort him with false hopes of rapid help. The results unfortunately have not justified these hopes. Inevitably, therefore, one finds that many more analyses are begun than ever are completed; and in this sad fact lies the explanation of many apparent psychoanalytic failures.

CHAPTER III

THE FREQUENCY OF THE SESSIONS

THE practice of psychoanalysis has evolved out of the experience of many mistakes; and each element of technique plays a part in avoiding their repetition. Therefore there is a reason for every sacrifice which the analysis asks of the patient. Of these sacrifices there is none which demands explanation more urgently than the daily session.

Basic Need for Daily Continuity in the Analytic Work

As the therapeutic work of analysis proceeds, old "forgotten" patterns of unhappiness are brought to light: old fears, and sorrows, angers, losses and frustrations. These come into discussion in each day's work; and as this happens their influence can be watched day by day in the life of the patient. Thus he can be

made to see and feel how they distort his current attitudes and his ability to deal with his immediate problems. The patient's present life is seen to be the screen on which the past continually throws its shadows. In order to achieve this insight, however, there must be incessant searching backwards and forwards between the past and the present so as to demonstrate the relationships and the parallelisms that exist between the two.

Therefore the psychoanalyst must maintain at every moment a watchful contact with many minute details of the patient's living. Each interruption of this intimate knowledge of the continuous stream of daily life temporarily throws the psychoanalyst out of that touch with current material without which the dynamic significance of the past is lost. Even the unavoidable interruptions at each week-end sometimes introduce a deplorable break in the momentum of the work. *The daily session, therefore, is a nearly absolute necessity. The casual interview, two or three times a week, may reach certain limited therapeutic goals, but can only rarely yield analytical data. For the sake of clarity such discontinuous inter-*

views should not be called "psychoanalysis", even when employed by a man who uses psychoanalytical technique in other cases.

The Temptation to Reduce the Frequency of the Sessions

There are many reasons why both physicians and patients are tempted to diminish the frequency of the analytic sessions. For the patient it means a lessened strain upon his time and pocketbook. Furthermore it seems to him that a day of freedom between the analytic sessions would offer a breathing-spell in which to carry on the day's activities without interruption. Superficially these are reasonable motives, but the loss of continuity in the work is too high a price to pay. Furthermore this prized day of rest usually means a day in which the patient's attention shifts from the analysis in a way which materially jeopardizes his progress.

One is justified in holding suspect the motives of the psychoanalyst who habitually reduces the frequency of the sessions. Every self-interested consideration inclines the busy practitioner to do this. If he gives each individual patient fewer appointments per week,

he can charge more per session, because obviously any patient for three interviews a week can afford to pay twice as much per session as he can for six. Furthermore, the "psychoanalyst" would then have more patients each week; so that if anything happened to one patient it would make a less serious difference in his income. The more patients he has at any one time the firmer is the structure of his economic life. No man, therefore, can be regarded as a conscientious psychoanalyst when he sees his "analytic patients" only two or three times a week.

Because it is popularly believed that long-drawn-out treatments and daily sessions are financially advantageous to the analyst, it is worth while to reiterate that these features, on the contrary, sharply limit his income. He would be both wealthier and more secure if he tempted more patients with hopes of short treatments and infrequent sessions. The dismal prospect of many months of daily work frightens off many possible patients, and the psychoanalyst who refuses to compromise in these matters will usually have to content himself

with a relatively modest and fluctuating income. On the other hand, anyone who habitually violates this fundamental feature of sound technique, claiming that "most patients don't need to come so often", is converting his own financial self-interest into a conscience-lulling edict. That his conscience is uneasy about it is shown by the fact that the "analyst" who indulges in this practice usually is evasive about it to his colleagues.

There are, of course, patients about whom there can be a legitimate difference of opinion as to whether or not they should be analyzed; but such patients are entitled to know what method of treatment is being used, i.e., whether they are being analyzed or whether they are being treated by some other psycho-therapeutic procedure which, however much it may be influenced by psychoanalytical theory, is not the application of the psychoanalytic technique. Otherwise, if the patient fails to improve, he cannot tell whether or not he has given psychoanalysis a real trial, and whether it is worth while for him to try again with a stricter application of the method.

The Wandering Analyst

The so-called analyst who oscillates between several places, spending a few days, a few weeks, or a few months in each, leaves behind him at each stopping place a group of incompletely analyzed patients as he moves on to the next. The foregoing discussion of the need for long and continuous work should make it clear that this is a practice which cannot be too strongly condemned. Concededly there may be practitioners of this kind who believe sincerely in the methods which they are using; nevertheless in the hands of unprincipled persons such procedures can be exploited all too easily as a mode of skimming the cream financially, with a complete lack of any conscientious regard for the suffering which it may produce and the harm it may do.

CHAPTER IV

THE TECHNIQUE OF FREE ASSOCIATION

IN psychoanalysis the daily search for unconscious material is conducted by means of a method which is called "free association". Historically, it is possible to see how this technique emerged after a series of experiments with other approaches; and the lessons learned from this experience have led to an increasing dependence upon free association as the essential tool.

Physiological Basis

The method of free association consists essentially in the application of the experimentally demonstrated fact that it is impossible for the mind to move from one thought to another unless there is an organic connection between them; just as it is impossible for a train to move from one station to another with-

out a connecting track. The old saying that "one thought leads to another" is based upon a popular realization that there must be some link between the two; and it is the function of the psychoanalyst to discover the nature and meaning of that link.

The psychoanalyst, therefore, is concerned not merely with the superficial logic of a patient's communications, but also with the sequence in time of his ideas and feelings. Just as Pavlov, in his work on the Conditioned Reflex, was able to prove that in a hungry animal no two experiences could impinge upon the nervous system without setting up a connecting link, the exact nature of which was dependent in part upon the time interval between them, so in psychoanalysis it has been possible to prove that ideas, feelings and actions which arise together must be bound to one another in some meaningful pattern. The nature of that bond and of the ideas underlying it are often hard to ascertain; and much of the work of psychoanalysis is devoted to this task of investigation and translation.

* Those who are interested in pursuing this rather technical point further may be referred to an article by the author

Thus it has been the contribution of a great Russian school of neuro-physiology to prove that time-relationships have a vital significance in psychophysiology; and it has been the contribution of the psychoanalytical school to make use of this fundamental principle in the study of unconscious psychological processes of thought and feeling.

Its Application

In applying this principle, the psychoanalyst asks the patient to do only one thing, namely, to go back to the simplest and most primitive of all methods of thought, to wit, to allow his mind to flow without guidance or direction, bumping along from thought to thought like a blindfolded man bumping from tree to tree in a forest. The patient is instructed never to withhold anything, never to reject one thought for another because the other seems more relevant, never to keep anything back because it seems impolite or unfriendly or a violation of a confidence, or because it seems trivial or unimportant. He is asked to tell everything that

in the *Archives of Neurology and Psychiatry*, Vol. 32, Dec. 1934, entitled "Relation of the Conditioned Reflex to Psychoanalytic Technic".

passes through his mind, and, as nearly as that is humanly possible, to tell it exactly as it comes to him. In short, he is asked to think aloud in the presence of the psychoanalyst, with that simple and naïve form of undirected musing which everyone uses in the solitude of his own chambers.

Inevitable Periods of Blind Searching

When the patient complies with this request and allows his thoughts to roam freely he gathers together a surprising array of apparently unrelated items. The well-trodden highways of his mind are soon abandoned and he finds himself in a seemingly trackless forest, following hidden paths from which he can emerge only slowly. Sometimes it is possible to see almost at once the direction of the patient's path, but often enough the analyst's task is more like the piecing together of a picture puzzle. Each day's work may bring its additional bit of data; but only as the fragments of the puzzle accumulate over weeks and months can the pattern of the whole be made clear. Therefore both for the patient and for the psychoanalyst there are repeated periods of searching during which no

immediate emotional gratification or relief can be expected. As long, however, as the essential free associations are coming from the patient without hindrance, the analysis progresses steadily.

This would seem to be a most simple and elementary task; but, as we shall see in the next chapter, it is one which soon carries the patient and the psychoanalyst into deep waters and through difficult and painful hours of labor.

Impossibility of Recording One's Own Free Associations

From this emphasis upon free associations, certain theoretical and practical consequences result. The patient who is allowing his thoughts to flow in this completely unguided fashion soon becomes lost in the labyrinth of his own associations. It is as impossible for him to recall such scattered, interrupted, and fragmentary thoughts as it would be to recall a long chain of nonsense syllables. If, after each session, a patient has too clear a recollection of the sequences of his own ideas, it is easy to prove that they have been produced not freely at all, but under the influence of some guiding

preconception and purpose. Even the trained introspectionist must observe and report his data systematically, and thus restricts the freedom of his material. Therefore, in order to study the uncharted paths of "unconscious" associations, there must either be an observer present to watch closely the patterns traced by the patient's productions; or else one must resort to some method of mechanical recording. It is possible to conceive that for research purposes a method of mechanical recording would be a valuable adjunct to use in addition to the human observer. From the foregoing discussion, however, it is clear that not even a trained psychoanalyst can be his own analyst. One cannot simultaneously be the miner and the assayer. One cannot produce ideas freely and at the same time record them and evaluate them; because the very act of observing and recording will in itself alter the sequence. Furthermore, for reasons which are discussed in the next chapter, it is inconceivable that the human observer can ever be dispensed with, however perfect the recording apparatus might be.

Let it not be imagined, however, that no orderly sequences of thought occur in the ana-

lytic session. From time to time throughout the analysis, and perhaps with increasing frequency as it progresses, the flow of ideas will spontaneously assume a logical, or narrative, or argumentative form, without interrupting deflections. The analyst is just as suspicious of a stream of thought that is always fragmented as he is of one that is always carefully organized.

This, then, is the essential tool of psychoanalysis—this technique of free association. To any honest skeptic the question must come, how can this help anyone? How can it help a neurotic patient merely to lie down and talk out his unplanned thoughts for an hour a day for weeks and months and years, sometimes about himself, sometimes about others? The answer to that question is our next task, and brings us face to face with the problem of the role of emotions in the psychoanalytic experience.

CHAPTER V

THE WORK OF THE ANALYSIS

"WHY does just lying down and talking do anyone any good?"

The Struggle Over the Production of Free Material

To his dismay the patient finds that the production of free associations is an unexpectedly baffling task. In the analytical situation this simplest and most primitive of all forms of thought proves to be the most difficult. From moment to moment the patient struggles with impulses to arrange and rearrange his words into pleasanter and more acceptable forms, that is, into forms which are more flattering to his own estimation of himself and to the impression which he wants to make. The severity of the struggle varies. All patients can achieve free and unguided speech only at in-

tervals; and every psychoanalyst has had the experience of having to work for weeks and even months in order to free a patient from inhibitions which have made impossible the consistent production of the essential psychological material. Perhaps the first important function of the psychoanalyst is to help the patient surmount these difficulties. The freedom with which associations are flowing is one indication of the satisfactory progress of an analysis. Without free associations there is no true analysis, because the essential material is not accessible to any other method which is available at present.

The Value of the Struggle

Nevertheless the analytic work which is done to clear away the emotional obstacles to the production of free material is not just so much time lost and effort wasted. Throughout the course of every analysis these stormy feelings are aroused repeatedly and have each time to be resolved. It is in this very process that the slow alteration of the patient's emotional responses is begun; and every bit of this work

adds to his insight into them. Thus, although it makes many phases of the analysis feel to the patient like a hopeless pitched battle with the psychoanalyst, the incessant struggle to maintain the free production of psychological data leads directly into an understanding of the patient's emotional organization.

The Dependence of the Biographical Analysis upon the Analysis of the Transference Situation

It must be remembered that psychoanalysis has two immediate aims. One of these is to survey unconscious psychological forces through the application of the method of free association. The other is to show the influence of these unconscious forces upon the patient's daily relationships to other human beings. Correspondingly, the psychoanalyst finds himself playing a dual role. In one he maps out for the patient a hitherto unknown psychic territory. He describes in a quiet, friendly, but impersonal manner the significant connections which he sees between the various components of the patient's free thoughts. This, strictly speaking,

is the psychoanalytical approach to an understanding of the patient's life history. The patient soon discovers, however, that this work cannot proceed in an emotional vacuum; and that no matter how quietly encouraging and impersonal the psychoanalyst remains, no matter how little the patient knows about him in reality, the analyst soon becomes the storm-center of highly-charged emotions. This is the second role of the analyst; and in order to make it possible for the work on the biographical material to proceed successfully, these stormy emotions must be watched for and anticipated, described to the patient sometimes before he is fully aware of them himself, and resolved through making clear their sources. This is what is known technically as "the analysis of the transference-situation"; and it can be seen that this must be a constant companion-piece to the biographical analysis. If it is neglected, the biographical work and the production of free material soon cease; and the analysis reaches an impasse.

The Dependence of the Analysis of the Transference-Situation upon the "Analytic Incognito"

From the point of view of the patient, the analysis of the transference is one of the most valuable of the experiences through which he goes. The reason for this is simple. The psychoanalyst himself should be a person who is little known to the patient. He keeps himself as much in the background as possible, out of clear focus and definition, quietly friendly, but always impersonal and reserved. He makes no show of his life, his work, his tastes, his pets, his family, his feelings, or his opinions. He becomes, as far as this is humanly possible, a mere peg on which the patient can hang his own phantasies. Therefore, when the patient's emotional relationship to the psychoanalyst is being analyzed, in actuality it is not a relationship to a real individual which is being studied, but rather the feelings which that patient might generate about almost any human being. Nonetheless in the presence of this obscure psychoanalyst, and towards him, the patient experiences moods of anxiety, anger, hate, affection, jealousy and the like, *usually at first without*

even realizing their presence at all. By proving the existence of these unfounded storms of feeling as they play into the analytic relationship, it becomes possible for the psychoanalyst to make clear to the patient how feelings of which he has been unconscious may warp his relationships to other human beings; and by unearthing the sources of these feelings in early childhood the analysis makes it possible to lessen their intensity. Thus by maintaining his formal reserve, his "analytic incognito", the psychoanalyst makes of himself a neutral sample of all humanity in the patient's life.

This, again, is why it is so vitally important for the patient that the psychoanalyst should be a stranger about whose personality he knows as little as possible. This is why it is unforgivable for a man to capitalize his social contacts and his friendships in building up an analytic practice. It is only with an unknown figure that the analysis of the transference-situation can be fully significant and fully therapeutic.

In summary, then, one finds that two great obstacles to the processes of free association are (1) the anxieties which patients feel at giv-

ing themselves up to the processes of free association in the presence of the analyst; and (2) the emotional storms which sweep over the patient in his relationship to the analyst. It is noteworthy that these same two interrelated processes form the greatest obstacles to free activity of any kind in the lives of human beings: to wit, anxiety in the presence of others, and blind emotional storms directed against others. This, then, is a fundamental reason why there must be not only a patient, but also a human psychoanalyst, in whose presence and on whom the patient works out his problems. And this is necessary, and will continue to be necessary, whether or not one finds it possible to make use of any accessory methods of mechanical recording.

Popular Misconceptions about the Transference

It should hardly be necessary now to stop to dispel the misconceptions which still are widespread about the transference situation. The life of the psychoanalyst might be pleasanter if the popular fancy that the patient "falls in love with" him did justice to the facts.

In reality we see instead that the patient struggles through phases of intense hostility, fear, and anger, as well as affection, admiration, respect and jealousy. It is inevitable that towards the psychoanalyst the patient will react with the patterns which are characteristic of his whole attitude towards life. All human relationships are compounded of variously mixed patterns of yearning, and the frustrations of this yearning which lead to anger, fear, and sorrow. These feelings may exist even when they are masked or disguised. The psychoanalyst attempts to give the patient clarity in his contacts with his fellows by giving him insight into the way in which these feelings work in him, the disguises which they may assume, the distortions which they introduce into his life. For a long time, however, it is chiefly as these feelings manifest themselves towards the veiled figure of the psychoanalyst that it becomes possible for the patient to recognize the fantastic and unconscious sources of these disturbing emotions. Thus the analysis of the "transference" helps to clear the air not only within the analytic situation but in all of the patient's life relationships as well.

The Couch

The reason why the patient is directed to lie on a couch during most if not all the analysis is implicit in the foregoing sections. In the first place, as has been said, it is necessary to conduct the analysis in the presence of a psychoanalyst. At the same time, however, it is important from the point of view of the patient to relieve him of the necessity of constantly observing the psychoanalyst and of adapting to his presence. The patient must be as relaxed as possible in order that he should talk freely. If he were face to face with the psychoanalyst, he would of necessity respond continually to the expression on his face, and to the indications of feeling which betray themselves in gestures. All of this would introduce distracting elements into a stream of thought which should proceed spontaneously from the patient's inner psychic life.

Furthermore, it is of advantage to the patient that the psychoanalyst be as relaxed as possible, so that he can listen to the patient's productions with a minimum of strain and the greatest possible freedom of attention. If the patient merely turns his back and sits in a

chair, the psychoanalyst cannot observe him at all. If, on the other hand, the patient lies on the couch, with the psychoanalyst sitting just behind the head of the couch, it is possible for the patient and the psychoanalyst to be equally relaxed, at the same time affording the analyst an opportunity to observe gestures or the expression on the patient's face when it is desirable to do so. Thus this minor element of psychoanalytic technique, about which there is much perplexity, resolves itself into a simple, sensible expedient.

The Direct Question vs. Free Association

The psychoanalyst makes a restricted use of any method of direct questioning. There are times, of course, when the direct question is essential, either for the eliciting of exact material or as a stimulus to further free associations. But for the most part the psychoanalyst has found that it is better to allow all the conscious historical data of the patient's life, all his conscious opinions and feelings, to express themselves spontaneously and without the restricting guidance of a questionnaire. This means a freer and at the same time a more disconnected

and less orderly sequence than would happen if the patient produced his ideas in response to leading questions. It makes the reconstruction of the patient's history take longer. But, on the other hand, the historical facts come to expression with a rich and varied background of free associations, which throw essential light on the emotional significance of the bare facts of history. There are plenty of occasions when the psychoanalyst must make use of the questionnaire method of gathering facts, notably with children, with frank psychotics, and occasionally to corroborate or correct data that his patients provide. At best, however, the facts so gathered can be used only as the patient elaborates upon them fully and freely. It is fair to claim, therefore, that histories which are gathered by the questionnaire method, even when intelligently applied with coöperative and intelligent patients, are barren and shallow as compared with the histories which are finally compiled slowly and with pain and trouble by the use of the method of free association from the same patients and on the same material.

"Homework" During the Analysis.

During the course of an analysis it is often asked by the patient whether or not he should think up things to talk about ahead of time and write them down, whether there is work that should be done outside, and whether he should read psychoanalytic literature. To such questions there are no universally applicable answers, but the general principles are implicit in the discussion of the nature of the process of free association. Certainly outside the analytic session the patient is free to think or write about anything that he pleases. It is essential only that when he comes into the analytic session he abandon all effort to guide his thoughts along the paths already traversed, and that, even if he finds himself using these topics as a starting point, he proceed from them with absolute freedom to let his thoughts rove as they please. Beyond that one may say that the amount of thought which a patient devotes to his analysis when he is away from it is sometimes an index of the sincerity of his analytic purpose. On the other hand, either an obsessive preoccupation with the analysis or an extreme inability to think about it at all are

alike in indicating the presence of unresolved emotional problems which are dealt with in the analysis itself.

For the rest, the value of analytic reading varies with different patients and in different phases of each analysis; and in every case has to be determined as the work proceeds.

The Role of Dream Analysis

It may well have occasioned surprise that throughout this discussion no mention has been made of the role of dream analysis. This surprise occurs because the analysis of dreams has been so much over-emphasized in popular literature on the subject. Dreams have always seemed mysterious and fascinating. The nightmares of childhood may remain vivid throughout a lifetime. The conjunction in dreams of fact and phantasy keeps alive the old yearning to be able to prophesy the future through their use. None of this, however, has anything to do with the usefulness of the dream in analytic therapy. In reality the analysis of the dream experience is conducted just as soberly and in the same way as one analyzes a waking experience. One finds that reality is interwoven

through the dream just as phantasy weaves its way in and out through actual events. The differences between a real occurrence and a dreamed experience are quantitative and relative, rather than qualitative and absolute. The analysis of the two yields much the same sort of information, each with its special advantages. In the dream, for instance, it is possible to see more vividly the fantastic nature of unconscious processes. Dream analysis, therefore, remains only one element in the complex technique of the analysis. Furthermore, under most circumstances, it is an element which is used sparingly.

CHAPTER VI

FREE ASSOCIATION VS. INTROSPECTION

PSYCHOANALYSIS is often accused of making patients morbidly introspective. This is an important problem and must be considered in relation to two separate phases of analytic work, first the approach to psychoanalysis, and second the process of psychoanalysis itself.

"Introspection" on the Path to Analysis

As will be seen in Chapter 8, on The Path to Analysis, there is a phase in the development of every patient in which it is necessary that he should realize fully the extent of his illness. In this preparatory phase he must become preoccupied with himself and his own symptoms. It is only through this that he finally reaches the point of facing his illness and seeking treatment. In this pre-analytic

phase the patient may well seem to be "morbidly introspective"; and insofar as the psychiatrist or psychoanalyst struggles to make a patient face his illness, holding a mirror up before his eyes so that he can see his difficulties more clearly, the tendency to introspection is increased. Furthermore, throughout the course of the analysis periods will recur in which the patient turns into himself emotionally, and struggles anew with the consciousness of illness and the realization of his own maladjustments. With each renewed struggle of this kind the "introspective morbidity" will reappear.

"Morbid Introspection" as a Symptom of Illness Rather than a Cause.—Contrast to Free Association

This, however, is a constructive necessity. Without such facing of reality no therapy, psychoanalytic or otherwise, is possible. Between this, therefore, and that which is popularly called "introspection" there lies a wide gulf. What the layman rightly objects to in morbid introspection is *in itself a symptom of illness and not a technique of therapy.* It

is a form of obsessive and solitary rumination which moves in unending circles which never progress to any goal. This obsessive rumination has nothing to do either with the frank acknowledgment of illness (on the necessity of which we are insisting), nor with the processes of free association which have been described in the last two chapters. Morbid introspection is an obsessional symptom, a distortion of the intellect in the service of unconscious emotional purposes. Free association is a method of breaking down this morbid form of introspection in order to bring the patient into a closer and more effective contact with life.

Of course patients who are afflicted with a tendency to obsessive and morbid rumination will at times distort the analytic instrument through this symptom. When this happens, however, the watchful psychoanalyst is quick to use this occurrence to make the patient aware of the symptom with which he is struggling.

One may say confidently, therefore, that despite the fact that psychoanalysis turns the attention of the patient on himself, it does so

in a form which is fundamentally different from that profitless introspection which is widely and justly condemned. In the end, furthermore, the successfully analyzed patient becomes less introspective and more objective in his living than even the so-called "Extravert".

The "Introvert" and the "Extravert"

It is a widespread popular phantasy that all victims of neuroses are "Introverts", by which the layman means people who are always charged with emotions and concerned primarily and exclusively with their own feelings. This is far from true. Every psychiatrist deals daily with patients of whom their friends and relatives say, "He's the last person in the world I would have expected ever to have a nervous breakdown. He never seemed to worry about himself. He was always active and made the best of everything."

The fact is that an extreme reluctance to face one's feelings may be just as serious a sign of maladjustment as an obsessive inability to think of anything else. Therefore, although the popular condemnation of obsessive solitary

introspection is sound, this should not be expanded so as to damn all properly guided investigation of inner psychological problems.

The well-analyzed patient does not end up unduly "introspective".

CHAPTER VII

THE CONTRAST BETWEEN PSYCHOANALYSIS AND HEALING BY FAITH OR BY SUGGESTION

Psychoanalysis Not a Faith Cure

The psychoanalyst expects of his patients a frank and open skepticism. Nothing excites in him graver misgivings than the bland credulity and pious faith which some earnest patients will struggle to maintain. He knows by experience that such attitudes, unless he can successfully break them down, will never yield lasting therapeutic results. He is no faith healer.

Faith Healing Without Differential Diagnosis

All methods of healing by faith are fundamentally alike. As a result of the basic premise

that recovery depends upon supernatural forces which affect all conditions equally, differential diagnoses are superfluous. Therefore no detailed investigation of the natural phenomena of disease is necessary, and there need be no history-taking and no careful diagnostic study. In contrast to this, psychoanalysis depends upon the investigation and treatment of each case as an individual problem, with long months of study before any far-reaching therapy gets under way. From this angle alone it would be hard to conceive of a contrast more striking than that between analysis and any form of faith-healing.

Relation to Exhortation and Suggestion

Furthermore, all methods of healing by magic depend upon some form of exhortation, a mobilizing of religious or personal enthusiasms. This is what a layman means by "suggestion"—first an emotional uplift which carries the patient out of one mood and into another, and in so doing obscures or gets rid of his symptoms for the time being; and secondly the influence of ideas to which the patient is introduced by the "healer". These ideas

work upon the patient largely through the emotional influence of the person who has presented them, and quite irrespective of their objective truth. The operation of all such suggestions is dependent upon the human relationship behind them. Break this relationship, and the patient usually regurgitates the ideas at once. This is one reason why hypnotism has persistently failed to produce lasting therapeutic results.

This again is far from the theory or practice of sound psychoanalysis, although much false pseudo-analytical work depends very largely upon such procedures. Similarly some (but not all) of the current Jungian practice seems to be an intellectualized form of faith cure, i.e., a combination of exhortation, mysticism and suggestion.

Difference Between the Utilization of the Personal Bond in Faith Cures and in Analysis

The objection may be raised that psychoanalysis, as well, works through a human relationship. This is true; but the bond is handled differently. Here the relationship between the

patient and the physician is not used to influence the patient directly (see Chapter 12) but rather to facilitate the production of buried material which would otherwise be inaccessible (*cf.* Chapters 4 and 5). As was explained in the discussion of the analysis of the transference, every effort is made not to bind the patient to the analyst and to his phantasies about the analyst, but rather to clarify these phantasies so that the patient progresses steadily towards greater freedom.

In all fundamental respects, therefore, psychoanalysis and healing by faith or by suggestion are at opposite poles.

Illusory Faith Cures

This is not the place to discuss the many arresting claims which have been made for the power of healing by faith. It is well to remind ourselves, however, how difficult it always is to know just what condition was treated, what unexpected changes in such conditions can occur under natural circumstances, and what the true relationship of the treatment was to the course of the illness. Every psychiatrist has had the experience of treating a slowly conva-

lescent patient whose illness yielded only at a snail's pace. In such cases well-meaning friends or relatives will almost invariably appear with the suggestion that the patient should turn to Christian Science or some similar therapeutic belief. If the patient attempts this during the deeper stages of the illness, he will fail. As the convalescence progresses, however, it will be a symptom of the patient's increasing optimism that it will become possible for him to respond to an optimistic philosophy. As this happens he may find himself seizing hold of Christian Science. This gives him a further boost; and as the ultimate recovery takes place the patient and his advisor become firmly convinced that he was cured by faith; whereas, as a matter of fact, his ability to accept an optimistic faith was evidence of an improvement already well-established.

In general one finds that the so-called "cures" of faith healing or by suggestion or hypnotism consist of a temporary alleviation of symptoms. As we have said elsewhere, however, (Chapter 8) the curing of a symptom may mean the obscuring of a disease; and this in the long run may actually be a serious dis-

service to a patient who would otherwise have been forced to face his illness fully and do something fundamental for it. Occasionally, however, affiliation with a religious sect may work a more fundamental alteration in a distorted personality, a change sufficiently profound to place it on a sound basis as long as the faith persists. These exceptional cases, however, are special problems, the nature of which we cannot discuss here.

CHAPTER VIII

THE VARIOUS APPROACHES TO PSYCHOANALYSIS

(1) THE PATH TO PSYCHOANALYSIS

PEOPLE may seek analysis for relief from a fully developed neurosis, or to prevent one, or to prevent the development or the recurrence of a psychosis, or to ferret out the cause of some unhappy maladjustment of their daily lives. In other words, psychoanalysis may be used for investigation, for therapy, and for prevention.

Analysis as a Last Resort

In general, however, psychoanalysis is still regarded as a court of last resort. In some ways this is inevitable. It is only natural to try to solve problems by quick and simple remedies until these prove to be ineffective. Furthermore, to seek analysis implies a painful acknowledgment of illness and of a grave need

for help. To most people of independent spirit this is impossible until they have first tried every other means which is at hand.

Patients are bound to make experiments with simpler remedies, therefore, until the psychoanalyst can convince them of his ability to differentiate those cases in which the simpler means are bound to fail from those in which they may succeed. It is often possible now for him to make such a distinction to his own satisfaction; but in the early phases of the development of a neurosis, patients and their families usually insist on making their own trials and errors in spite of what the psychoanalyst may advise.

The Effort to Solve Internal Problems by External Manipulations

Therefore the histories of neurotic patients who finally come to analysis uniformly give evidence of repeated efforts to solve internal difficulties by external changes. Childhood problems were attacked by changes in disciplinary regime. Difficulties in school were approached by changing schools; or else the hope was entertained that all would be smoothed

out with the shift from elementary school to high school, from day school to boarding school, from school to college. In college again it was expected that life would be better after graduation. Then the solution was sought in a job, in changing jobs, or in marriage, and then in having first one child and then several, or finally by divorce and possible new marriages.

Such external changes sometimes succeed; but unless they are accompanied by profound psychological readjustments they more often merely transfer the old problems to the new setting. In the end every adult finds himself facing a life in which every important kind of change which can be made has been tried, and in which no further significant alterations in the outer forms of living remain to be tested. Only then does he stop to examine himself. He would have saved himself and those near to him much suffering and many years of frustration if years before he had been ready to make the acknowledgment of illness without which no psychotherapy of any kind could be undertaken.

Futility of Compulsion, Cajolery, or Bribery of the Reluctant Patient

It is futile, therefore, to compel or beg or cajole or bribe a patient into going through the forms of treatment. For the reluctant patient one can do only a few things: one can hold a mirror up to him so that he must see his own sickness; one can hold out to him the legitimate expectations of relief through honest, hard analytical work; and one can induce the family to take away every protective arrangement whereby the patient is saved from suffering the consequences of his illness. This is the only effective ante-chamber to psychoanalysis, or for that matter to any effort at psychotherapy. The patient must be made to feel painfully his own need for help, before any outsider can help him.

The Patient Who Comes for the Sake of Someone Else

The patient who comes only to please someone else confronts the psychoanalyst with a difficult dilemma. He may recognize in the patient a grave need of which the patient himself is entirely unaware. If the psychoanalyst then

paints a true picture of all the time, effort, and money which the patient will have to expend on treatment, no matter how grave his need the patient will almost certainly run away at once. This in a sense is a therapeutic defeat; although ultimately, as his illness continues to take its toll of his life, such a prospective patient will sometimes return.

If on the other hand the psychoanalyst passes lightly over the difficulties, obscuring them, playing for a warm and friendly contact, he can often inveigle such a patient into beginning an analysis. The patient will usually improve for a time under the spell of his first emotional attitude to the psychoanalyst; but gradually, as the fundamental problems reassert themselves and the inevitable difficulties begin to appear, the lack of a clear personal purpose in the analysis will make itself felt. Such a patient will turn away bitterly from an incompleted treatment, convinced that he has tried psychoanalysis and found it wanting. Therefore, although it seems callous, it usually is wiser to send such patients away to wait until their increasing disabilities finally force

them to come back with a determination that will carry the treatment through.

(2) PSYCHOANALYSIS AS A PREVENTIVE MEASURE

General Movement Towards Preventive Measures

The growth of the influence of psychoanalysis has coincided with the development of the mental hygiene movement, and with the increasing emphasis on preventive medicine in general. Before the introduction of psychoanalysis, therapy in psychiatry was large palliative. Practitioners of psychiatry discarded the brutality of the Middle Ages, and by returning in modern hospitals to methods which had been in vogue in ancient Greece they succeeded in making their patients' lives more comfortable. By hypnosis and allied procedures specific symptoms could sometimes be eliminated. It was not, however, until the evolution of the psychoanalytic technique that the complex psychological roots of the neuroses could be investigated and altered.

From Therapy to Prevention. Psychoanalytic Recognition of Early Phases

These therapeutic gains led to efforts to use psychoanalysis as a preventive measure, efforts which were stimulated further by the fact that many mental illnesses begin insidiously and progress by resurgent episodes of increasing severity. It has been reasonable to hope that one could check the advancing tide of illness by applying these new methods before the neurosis developed fully. Furthermore, training in psychoanalysis sometimes makes it possible to recognize incipient phases of illness before the patient or his family is aware of the imminence of danger.

Equivocal Position of the Psychoanalyst

Strangely enough, this ability to foresee future difficulties sometimes places the psychoanalyst in an equivocal position. He must often try to convince a patient that he is potentially sicker than his conscious complaints seem to indicate; and he must convince a doubting family and the family physician of the truth of the same unwelcome verdict.

In this respect old-fashioned psychiatry,

which dealt only with outspoken disease, was on a par with all other medical practice. The patient's illness was obvious even to the most casual layman. When the doctor said to the family, "This is a sick man who must be treated", no one could call him an "alarmist", or accuse him of manufacturing an illness in order to increase his practice.

Psychoanalytic psychiatry, however, in attempting to prevent the development of serious psychotic and psycho-neurotic outbreaks, is dealing with personality disturbances of a subtler nature. The psychoanalyst must often say to the family, "I know that this person looks normal to you, but in him I can see the seeds of later illness. Therefore you had better let him go to an analyst every day for many months, at a great sacrifice of time, energy, and money, in order that the analyst may attempt to prevent the development of the sickness. Then, if he is successful, this sickness will never occur, and you may always think that it might never have developed." He is thus in the unenviable position that if he succeeds, he can never prove that his alarming prophecies would have materialized. If, on the other hand,

he fails, and illness develops, either the illness will be attributed to his intervention, or at the least he will be accused of having taken money under false pretenses. Whatever happens there will always be more than one friend and relative of the patient who will think that he has been misled into unnecessary, extravagant, and unwise treatment.

Under these circumstances there is only one attitude which the psychoanalyst can take: and that is to invite honest and open skepticism from the friends and relatives of his patients. To expect more than this is to hope that they will look upon him as omniscient. This skepticism should be open, however; which means that the responsible friends and relatives must feel free within reason to express their doubts frankly to the psychoanalyst, and that he must make himself hospitable to their misgivings before the treatment begins.

Even in these circumstances, however, the psychoanalyst is at a disadvantage, because frequently the symptoms which the patient reveals to him are hidden from the rest of the world, and it then becomes the psychoanalyst's duty to protect the patient's confidence by

limiting himself to indicating that there are serious symptoms which he does not feel free to discuss with anyone except the patient. If the responsible members of the family doubt the physician's word on such a point, and if they are responsible for the patient's treatment, they would better take the patient out of the psychoanalyst's hands entirely. And the psychoanalyst, in turn, should be happy to be rid of such an ungrateful responsibility, because in the end their interference would only frustrate his efforts.

In such situations and when dealing with a neurotic or suspicious family it may sometimes be possible to lessen their skepticism by refusing from the outset to consider taking the patient one's self, and insisting instead on acting only in the role of the advisor who refers the case finally to some other qualified psychoanalyst. This reduces the suspicion that the psychoanalyst's judgment is influenced by mercenary considerations. The basic solution of this whole problem lies not in any such device, however, but in the steady growth of confidence in psychoanalytic judgment. This will

come when the general public learns to deal only with those who are qualified to practice by the long and thorough training described in Chapter 9. Otherwise the effort to use psychoanalysis for preventive purposes will remain open to unscrupulous and uncontrollable exploitation by untrained men.

The "Mild" Neurosis as a Danger Signal

There is another form in which the problem of preventive therapy frequently presents itself to the psychoanalyst. His advice may be sought by a patient who comes in with some mild neurotic disturbance, a complaint which obviously will yield quickly to almost any kind of sensible and superficial help. Behind that specific symptom, however, the signs of a more profound disturbance may be discernible. The decision must then be made whether it is better to cure the specific symptom which has brought the patient, or to use it as a lever with which to open up the deeper difficulties.

The former is easy to do. The patient goes away happy and grateful. But the underlying illness goes on; and at the next severe strain

a more obstinate and extensive outcropping of symptoms appears. One has cured a symptom and obscured a disease. It is comparable to the danger of masking the diagnostic symptoms of an acute surgical emergency by a too free use of morphine; yet the opportunist in the field of psychiatry will always choose this course.

The other alternative is to refuse to treat the symptom directly, using it instead to force the patient's attention to his more deep-seated problems. The patient will soon feel worse instead of better. The family will become indignant and alarmed. Yet every step along this path means progress towards that frank facing of illness without which no lasting therapy can occur. If properly forewarned, and if the patient's capacity to stand the rigors of this treatment has been accurately gauged, the results in the long run justify the pains.

To accept with equanimity and unshaken confidence an increase of the pain from which one is seeking relief demands an almost blind trust. Here again, however, the only safeguard which the layman can have is the adequacy of the psychoanalyst's training.

Psychoanalysis vs. Trial and Error

All forms of education are attempts to avoid the waste of human time, effort, and energy, which is involved in the method of trial and error. Not that it is possible or even desirable wholly to avoid the experimental attack on life, with its inevitable mistakes; but it is naïve to imagine that trial and error are always conducive to learning. Often they involve a useless and compulsive repetition of old blunders. It is for this reason that one so often hears the complaint that someone is "unable to learn from experience". For neurotic patients, therefore, in whom the tendency to the compulsive repetition of mistakes is strong, psychoanalysis is an indispensable *method of economy.* For all human beings it is conceivable that it might achieve a reduction in the amount of wasted and unnecessary trial and error which life entails; but for the neurotic patient it alone can prevent the cumulative recurrence of tragic errors. Therefore the question arises—how early in the slow development of a neurotic personality should analysis be attempted?

When should Analysis be Attempted?—The Waste and Dangers of Waiting too Long

Take, for instance, a frequent problem: that of the young spinster in her early thirties. She has never been thoroughly happy in social relationships; she has never been adequately trained for any occupation; she has manifested veiled emotional and neurotic disturbances for years, but she has always run from them. She has tried vacations abroad and at home. She has tried shifting from one social group to another. She has tried Christian Science and social work, theosophy and art. But as the years have gone on, for reasons which she cannot explain, frustration and defeat have piled up, until suddenly she is confronted by the specter that she has always dreaded, the fear of becoming an old maid. Now, however, this fear is complicated by the factor of reality; because she has reached the time of life in which most marriageable men are already married. She is thrown into constant contact with desirable men who are, however, not available (i.e., the husbands of her friends), or with those

who, like herself, have remained unmarried for neurotic reasons. Therefore she suffers repeated disappointments and clutches desperately at hopeless and inappropriate straws. Finally some ultimate disappointing episode upsets the applecart and precipitates her into a serious and prolonged "nervous breakdown" (that is to say, into some fully-developed form of emotional or mental disturbance).

If we follow the course of such a patient a little further we encounter another significant fact—namely, that the fight is not won even when the patient recovers from this illness. She emerges from the acute upset to face the same external problems and the same inner neurotic mechanisms; and even if analysis, or any other form of treatment, now frees her from her neurosis, the difficult situation remains. Indeed the patient who is cured of a profound neurosis in the middle or late thirties or in the forties is like a prisoner coming out of prison. No magic can restore the lost years, nor make the road ahead an easy one.

The Practical Human Reasons for the Tendency Towards Earlier Analytic Help

When should such a patient have been analyzed? There would have been an opportunity in childhood, when temper-tantrums, night terrors, and excessive dependency upon adults were first manifested. There would have been an opportunity in adolescence when the patient had a short but serious emotional upset on going away from home to school. There would have been an opportunity in the early twenties when the patient's social uneasiness, her lost attitude in the world, her emotional swings, etc., became a little clearer. Sometimes these opportunities are missed because families are proud and refuse to recognize the existence of a neurosis in their midst. Sometimes they are missed because the patient herself is proud and defiant, or secretive and ashamed, and rejects the best-intended efforts of the family to lead her to help. Either way the delay is tragic in its implications for the patient's life.

Comparable to such a case may be the fate of the bachelor who comes to the analyst at a similar age. He has been disappointed not

only on the emotional side but also in his work-life. He has met defeat because of neurotic obstacles within himself which have stood between him and success. Here again the patient, even after successful analytic treatment, comes out of prison to face a world in which his opportunities for training and for work are seriously curtailed. His bungling progress through school and college and professional school, or through the early years of a business or professional career, has left behind him a record marred by the evidences of his neurotic struggle, a record which does not do justice to his latent abilities. In turn such a record blocks his future opportunities. Therefore, even after restoration of health and with freedom from his neurosis, he faces a difficult task. Sometimes he must turn back to train himself in competition with people twenty years his junior. Sometimes he must abandon one field of work for another. These are difficult readjustments to make; and for all these consequences of years of neurosis, analysis has no magical assuagement.

Again, therefore, one faces the question, when had it best be applied? Should it have

been done in the early years in which the transient neurotic outbursts of childhood gave warning of possible future difficulties? Or should it have been in adolescence, or at the recurrence of difficulties in the twenties? Certainly if he could have been brought to treatment earlier, many years of tragic waste and frustration would have been spared him. These are some of the considerations which make one recommend that treatment be instituted just as early as the patient can be brought to realize his need of help. *This means that it is rarely wise to wait and see if a patient won't "grow out of it"; and never wise so to protect a patient that it becomes easier for him to live with his neurosis than to face the rigors of treatment.*

(3) WHO CAN BE ANALYZED

Personal Conviction of Need

Whether as therapy or as prevention, psychoanalysis can function effectively only for someone who has become convinced of the necessity of the step he is taking, who faces honestly his own neurotic tendencies, who has abandoned the effort to blame his maladjust-

ments entirely on external circumstances, and who comes willingly and largely on his own initiative. Obviously, then, in many cases, and especially in the effort to prevent the development of illness before it has made itself fully manifest to the patient and to his relatives, the analyst must prepare the patient for the analysis by bringing him to this fully coöperative viewpoint.

Intelligence and Age

One is often asked how essential for an analysis are education and intelligence, and whether there are any age limits outside of which psychoanalysis becomes impossible or powerless. These are not matters about which one may become dogmatic. It is certain that in general a fine intelligence is an asset, but that formal education matters little. There have been efforts to study by psychoanalytic methods primitive savages, simple people in our own society, and even the mentally defective, and in the latter case to alter their sudden emotional tantrums. The immediate practical value of these studies is less clear than their scientific interest.

Infants

Not dissimilar problems arise in the psychoanalytic investigation of infants before the age of spoken language. Technically it comes down to the question of how gestures, play, direct emotional expression, and the like, can be used as a substitute for the spoken word in tracing the patterns of free associations (See Chapter 4). Much important research centers about this problem, and results have been achieved which are theoretically illuminating and therapeutically gratifying.

Children

With older children no such technical difficulties exist; and in this age-period the exploration of unconscious influences and their conscious resolution is an important phase of current psychoanalytic development.

Adolescence

In adolescence the only obstacle to successful work is the patient's temptation to blame his difficulties on the vicissitudes of home, school and college, and to reject all personal responsibility for the task of getting well.

Sometimes it may be so difficult to overcome this that the youth must be allowed to flounder until he is convinced of his need. Where, however, the adolescent neurosis contains any hints that there is danger that a permanent mental illness may develop, one dares not sit by idly waiting for the patient's sense of his illness to develop. By that time it may already be too late to help.

Advanced Years

Old age, too, brings its perplexities. Beyond a certain age one would hesitate to recommend any form of treatment which must of necessity last so long. That "certain age", however, is something that must be determined for every patient individually. What one person can no longer undertake profitably at forty-five, another might carry through at fifty-five or sixty. Into that decision will enter many considerations: the duration of the neurotic difficulties, the patient's earlier flexibility and health in meeting the challenges of life, the social, familial, and economic problems which the patient has to face, etc. The decision will

rest on grounds of practical common sense, as well as on technical issues, and must be thoroughly discussed between the psychoanalyst and the patient or his family before undertaking the treatment.

CHAPTER IX

PSYCHOANALYTIC TRAINING

(1) HOW ARE PSYCHOANALYSTS MADE?

The Use of the Name

In all of medicine and surgery there is no apprenticeship which takes longer than that to which the present-day student of psychoanalysis is subjected. For the use of the title "psychoanalyst" there are no copyrights; but certainly there is a moral right which should make it increasingly difficult for anyone to call himself a psychoanalyst who has not subjected himself to this discipline.

Historical Abuses

In the days when psychoanalysis was taking its first hesitating steps, anyone who was interested could join a "Psychoanalytic" society which met at intervals to discuss the new science and to listen to lectures on the subject.

At any time a member could launch himself in the practice of something which he called "psychoanalysis". Thereafter his independent experience and his study of the writings of others, his inherent gifts, and his integrity, would determine his further growth. Many able pioneers grew up under this regime. The going was hard and the material rewards were limited, so that for a few years there was no incentive to the opportunist to join in.

With the growing popularity and importance of psychoanalysis, however, this lack of restrictions led to abuses. Many people began to call themselves psychoanalysts who had no conceivable right to the name, and who by no process of self-training or discipline ever achieved any understanding of the fundamental principles of what they claimed to practice. To this day many people are regarded as psychoanalysts, both by the laity and even by some of the medical profession, whose methods are completely at variance with every essential of psychoanalytic technique. Some of them have been members of a psychoanalytic society. Some have never had even that justification. Thus many things have been done in the name

of psychoanalysis that should not in fairness be laid at its doorstep.

These abuses are at times incredibly gross. A sign in a window claimed that the man within was a "Chiropractor and Psychoanalyst". Another man boasted that he could "analyze" his patients in an hour. A glib and popular physician, without training either in psychiatry or psychoanalysis, talks of "working the transference on" his "analytic" patients. A psychoanalyst was consulted by a woman who was desperately in need of treatment, but who rejected it because she had been badly mismanaged and thrown into a panic by a physician who told her she was being analyzed when she was seeing this physician for one-half an hour once a week for a period of a few weeks. Fortunately with the growth of popular understanding such grave blunders as these are gradually disappearing.

Self-Styled "Psychoanalysts"

There is a subtler form of abuse which persists, however, and which can be stamped out only with the full coöperation and help both of the laity and of the medical profession in

general. This is the misuse of the term "psychoanalysis" by physicians who may have acquired their training in other fields of medical or surgical practice. Such cases are not infrequent. Any physician is likely to find himself drawn into the ever-present emotional problems of his patients. He may develop an aptitude for this sort of work, and have one or two successes. Before long, without even a rudimentary training in fundamental psychiatry and neurology, much less any training in psychoanalysis, he is "analyzing" his patients. There is no consultant in the field of psychiatry and psychoanalysis who has not had to pick up the pieces after this sort of malpractice.

Occasionally such men, under the stress of unexpected difficulty in their work, apply to the Educational Committee of the Psychoanalytic Institute for instruction. If they agree to accept the jurisdiction of this training body, to fill in the gaps in their earlier education, and to put themselves through the course of further training laid out for them, such applicants are welcomed. The sacrifices involved are heavy, however, including as they do the abandoning of all the pseudo-analytical prac-

tice which they have been conducting; and few indeed complete their apprenticeships. In fact many such applicants fail even to begin it when they find out how great a sacrifice is involved and how exacting is the discipline.

The "Psychoanalyst" by Grace and Intuition

There are other physicians who sincerely believe that a certain "flair" for human contacts is the equivalent of a psychiatric and psychoanalytic training. It is as though a man's confidence in his "clever hands" justified him in not schooling himself in surgery before launching himself upon the public as a surgeon. Yet there are physicians who, solely on the basis of an interest in the problems of human nature, do not hesitate to purvey to the public a personally blended form of psychotherapy in which they include a few of the more superficial features of psychoanalysis. Such individuals in the presence of antagonists explain that what they practice is *not* psychoanalysis; but in the presence of a more friendly group insist with equal vigor that it is. Obviously this is a deplorable procedure, sometimes under-

taken in all sincerity, sometimes as a product of the physician's own unrecognized neurosis, sometimes out of flagrant opportunism.

None of these abuses can be controlled by law; but the public can protect itself by dealing only with those men whose training has been long, devoted and thorough, and who have met the exacting standards of the training committees of recognized psychoanalytic institutes.

Training Institutes

It has been for the purpose of combating just such abuses as these that special institutes have been developed to train those who wish to master this particular branch of medical therapy. As a result, all young students now undergo a process which attempts both to weed out the unfit and to train the survivors thoroughly. The more conscientious of the older men have put themselves through the equivalent of this discipline. There are some, of course, whose training remains defective; but their numbers are gratifyingly small, and the passage of time will correct even this situation. Therefore the training given by a recog-

nized psychoanalytic institute (*vide infra ch. IX*) constitutes the best available assurance of the honesty, integrity and ability of a psychoanalyst, and is the only objective evidence of a physician's right to call himself a psychoanalyst, and to call that which he practices psychoanalysis.

The International Psychoanalytic Society

Before describing this training further, it is worth while to refer to the organization by which it was first elaborated. This organization is a voluntary guild, known as the International Psychoanalytic Society, and consists of constituent societies in many lands, whose membership comprises the membership of the International body. This international group is thus a federation of local educational guilds; and membership in it comes by election to the local societies after a period of training and apprenticeship. Membership, therefore, carries the meaning that the individual psychoanalyst has put himself through the long and arduous task of training, on the general principles of which the International Society and its scattered branch societies have agreed.

Factional Dissension During Process of Raising Standards

This is a sound plan of organization, and one towards which the responsible leaders in psychoanalytic thought have been struggling for years. An unswerving adherence to a high standard is not achieved easily, however, nor without occasional opposition. In many places the organization is new, and the training regulations can only gradually be put into full force. In the struggle to raise standards, every effort is made to avoid splitting into conflicting psychoanalytic societies, because of the confusion which this produces in the minds of the public. Where, however, divergent policies force such a split, the medical public and the laity in general must make its own inquiries and satisfy itself as to which of the conflicting bodies represents the higher standards of training and of practice.

The American Federation

In America there has been for many years a society known as the American Psychoanalytic Society. For the larger part of its history, however, this society represented a conglom-

eration of highly diversified technical methods and aims, in no true sense psychoanalytic in its fundamental scientific point of view. Nor did membership in the society rest upon any prerequisites of training. Within the last few years, however, an effort has been made to change this organization so as to convert it into a federation of local societies, in all of which high training standards would be faithfully enforced. When this change is completed, membership in the American Psychoanalytic Society will depend upon membership in a local organization, which in turn will have the power to enforce high standards of training upon all new students of psychoanalysis.

Training by Apprenticeship Under the Guidance of Educational Committees

Not all the local branch societies which make up this federation are empowered to conduct educational institutes. This is because in some

* The American Psychoanalytic Federation is not to be confused with the so-called Psychoanalytic Section of the American Psychiatric Association. Up to the present time there is no provision that members of this section must be trained in psychoanalysis. Membership in it, therefore, is evidence only of an interest in the subject, not of adequate training in its use.

of them the membership is still too few or too heterogeneous, or else too newly-organized for full educational responsibilities. In those branch societies which conduct educational institutes the supervision of all training is delegated to a specially elected Training Committee. This Committee organizes the courses, selects and rejects students, supervises their training and finally recommends them to the society for election to membership as a form of "graduation".

The steps in the selection and training of a student are as follows:

Freedom from Neurosis

(a) The student must first apply to the Training Committee of the Institute. He is questioned carefully, and is interviewed by a special subcommittee. The purpose of this close scrutiny is to eliminate applicants who are themselves suffering from active neuroses. Such applicants are frankly told that they must undergo treatment and present evidence of sound mental health before they can even be considered for training.

Training in Medicine, Psychiatry and Neurology

(b) Once the Committee has satisfied itself that the applicant is healthy from the emotional and neurotic point of view, his academic qualifications are considered. Not only is graduation from a Grade A medical school required, but also a thorough hospital experience in psychiatry and an adequate training in the fundamentals of neurology.

The Didactic Analysis

(c) When the applicant satisfies the Committee as to his fitness with regard to the first two qualifications he is formally registered and enters upon his first actual step in training: that is, he himself becomes a patient in a training or "didactic" analysis. This analysis must be conducted by a psychoanalyst who is one of a list that is chosen by the Educational Committee of the society from among the members of the institute, very much as the faculty of a university is selected.

The duration of this training analysis varies considerably; and the factors which determine

its length need not be gone into in detail, as they are for the most part purely technical. It is enough to say that training analyses never last less than a year, and usually last much longer. Certainly the training analysis must be at least as thorough and as deep as the therapeutic analyses which that candidate will be conducting later. As a matter of actual experience, every "didactic" analysis in the end becomes as truly "therapeutic" in its method and goal as does any other.

Formal Courses of Instruction. The Pledge

(d) At some point during the conduct of the training analysis the student is allowed to attend theoretical and technical lectures, case discussions, reading courses and the like. This is his first formal contact with the teaching activities of the Psychoanalytic Institute; and before taking this step he is asked to pledge himself not to start psychoanalytic practice until he shall have been accepted and passed by the Training Committee. It is this crucial test that leads the pseudo-analyst to seek his "training" elsewhere.

The Controlled or Supervised Analysis

(e) In the course of time, as the training analysis nears completion, and as the student builds up his knowledge of theory and technique, he is assigned to his first cases. These first analyses are conducted under the supervision (or "control") of some more experienced training analyst. To this supervisor the student must bring the material of his patient, usually at least once a week, for review, criticism, and suggestions.

"Graduation" by Election

(f) Finally, after the successful conclusion of several such supervised analyses, the student's status is again reviewed by the Training Committee; as to (1) his pre-analytic experience and training, (2) any additional formal training in psychiatry that he may have been required to add in the intervening years since his original application, (3) his work at lectures and case discussions, (4) his presentations of his own work at seminars and society meetings, and (5) his work both as a patient during his own didactic analysis and as a psychoanalyst during his conduct of his super-

vised analyses. If no further doubt exists as to his fitness and qualifications, he is recommended for election to membership in the Psychoanalytic Society.

The Training Institute as a Moral Guild

Some of the institutes (e.g., the New York Psychoanalytic Institute) have state charters as recognized educational bodies. This, however, gives no legal power to enforce these exacting standards. Nevertheless the moral force of these institutes is making itself felt increasingly. Such guilds are conducted by psychoanalysts at the cost of much time and labor, and at their own expense. They exist not in order to limit the number of "competitors", but to train younger colleagues so that they shall become competent practitioners of psychoanalysis. The ultimate force of the societies and of the institutes depends upon the support given them by physicians in general, and by the public; and this support can be given only by making it a rule to ascertain whether any man who claims to be a psychoanalyst is or is not a member of the Psychoanalytic Society. This information can be secured

by direct application to the Secretary of the Society (See Appendix).

Duration and Expense of Training

Such a training as this, from the time of graduation from medical school, through the required internship in hospitals, through the period of analytic work itself, to the ultimate admission to the society, may take several years. For the student the only heavy expense is his personal analysis; and endowment funds must ultimately be secured to help promising students who are unable to meet the entire expense of their training themselves. At present, in the absence of such endowments, the individual training-analyst makes a disproportionate sacrifice by conducting didactic analyses often with little or no pecuniary compensation for the many hundreds of hours which he diverts from his own practice to the training of his younger colleagues.

It is worth while to note in passing that the Psychoanalytic Institute exists, not only for the training of younger students, but also for the continued development and further training of all the members, for whose benefit

advanced courses are given with technical discussions of special problems.

The Practical Definition of a Psychoanalyst

We may safely conclude, therefore, that, in the interests of the public and of the medical profession in general, one may define a psychoanalyst as one who is a member in good standing of any Psychoanalytic Society which is in turn a member of the international body. It is in the interests of clarity and of the practice of sound medicine to refuse the name of psychoanalyst to anyone else. And it is a wise precaution to find out whether any man who calls himself an analyst belong to such a society before accepting him as an adequate exponent of a method which he is supposedly applying. This conclusion is in agreement with the opinion of the British Medical Association quoted in Chapter 1.

Lack of Organized Training Standards in non-Freudian Groups

Finally one may point out in passing that none of the conflicting schools of psychological therapy, which have grown out of Freudian

psychoanalysis, have developed organized methods or standards of training which approach even remotely this severe discipline.

The Danger of Overstandardization

The one criticism which may justly be levelled against the Freudian system of selection and training is that there is danger of overstandardization. One cannot brush this criticism aside. Yet in this particular field of work, where the danger of untrained and dishonest practice is so great, one runs the lesser risk by turning to the carefully trained man. In the long run well-educated men do not remain slaves to any theoretical system; and that there has been a normal amount of free growth and development within the psychoanalytic point of view is shown by the frequency with which it has been accused of inconsistency because of changes which have occurred in its theories in the course of the years. Those who have left it (Jung, Adler, Stekel, Rank, etc.), have done so not because of Freudian intolerance for change and growth, but because they have turned to a fun-

damentally different point of view on causation and treatment.

(2) THE PROBLEM OF "UNORTHODOXY" IN PSYCHOANALYSIS

Freudian Training Basic and Open to All

This is no place for discussion of the differences between the theories of the Jungians, the Adlerians, the Burrows group, Stekel, the Rankians, etc. No one group can lay claim to a monopoly on all truth; and certainly the Psychoanalytic Society and Institute, with its distinctively Freudian approach, can set up no claims to omniscience. It can claim only the absolute integrity and fairness of its training regulations. Any honest, healthy, non-neurotic, well-prepared, and intelligent physician can put himself through its apprenticeship.

Full Training Possible Only in Such Institutes

In this peculiarly confidential field of medical practice it is only through work in such institutes that the physician is given the opportunity to subject his work to the scrutiny and criticism of his colleagues. More than any

other branch of medicine, psychotherapy has to be conducted with privacy. This makes it peculiarly difficult to know just how a colleague works. The only possible way of observing another's skill in order to increase one's own is through the apprenticeship of the institute. Under these circumstances it does not seem unreasonable to demand that those who are drawn towards the "unorthodox" experiments should first perfect their understanding of the more fundamental Freudian discipline. Upon this as a basis, anyone is free thereafter to make whatever new departures his own scientific ingenuity and skill make possible.

Orthodoxy in Technique Rather than in Theory

Furthermore it should be borne in mind that the struggle for "orthodoxy", in Freudian psychoanalytic sense, is not concerned primarily with matters of theory at all, but with the problems of technique. No one accuses a surgeon of being too orthodox because he subjects himself to the rigid discipline of aseptic surgery. No one accuses an experimenter of being

too orthodox if he scrupulously avoids introducing unknown variables into a complex experimental situation. Similarly everything in the psychoanalytic method has grown out of the need to create a situation in which external variables are reduced to a minimum in order to facilitate the production of psychological data which shall be truly free, unguided and undistorted. Without such a technique there is no such thing as psychoanalysis; and important though the inner gift may be in all students of psychology, it is no adequate substitute for discipline and training in the use of such a highly complex and unfamiliar instrument.

In certain cases the theories and practices of these "unorthodox" groups are diametrically opposed to some aspect of the Freudian discipline. In other instances a single Freudian concept is given undue emphasis and is regarded as an adequate substitute for all which is omitted or rejected. The Freudian feels, therefore, that his emphasis on "orthodoxy" is not a rigid dogmatism but a justified insistence on the need for a fundamental and inclusive basic training.

(3) THE PROBLEM OF THE NON-MEDICAL PSYCHOANALYST

No question has given rise to more dispute than the problem of the lay-analyst. One is always loath to open the door to the practice of medicine in any form by medically untrained people, however upright their motives and however skillful their personal technique. There is always grave danger from the abuses which can arise under such a system, so that one hesitates to make any exception to the general rule.

The Trained Layman vs. the Untrained Physician

To many people, however, it seems that if it is ever safe to make such an exception it can best be made in this particular field. Certainly it is true that the effort of the inadequately trained physician to practice psychotherapy or psychoanalysis is open to abuses at least as grave as is its practice by a well-trained layman. On the other hand, in the treatment of any human being the interplay of physical and psychological factors has to be carefully

watched at all times. The unexpected eruption of physical disturbances in the course of psychological illness is an ever-present possibility, and sometimes the differentiation between the two is by no means easy. It is fair to assume that under ordinary circumstances the medically trained psychoanalyst will approach these problems with a more open mind than will the layman. But, on the other hand, a well-trained layman can be taught a proper respect for the body, and can be bound by an agreement to accept patients only after a thorough medical and psychiatric examination, and also to insist that his patients keep under medical supervision throughout the analytical work. Theoretically, therefore, it is possible so to safeguard the patient as to make an analysis by a well-trained layman a reasonably safe procedure.

Possible Scientific Gains vs. Immediate Social Dangers

It may well be asked, however, whether there are any advantages to be derived from the practice of psychoanalysis by people who are not trained in medicine. This question is

difficult to answer in general terms. From the point of view of psychoanalytical science, there is much to be learned from the contributions of a group of specialists in such fields as anthropology, ethnology, philology, mythology, and the like. Psychoanalysis needs their special knowledge, and in order to secure from them all that they have to offer they in turn must have a thorough grounding in psychoanalysis. Such a training, to be complete, includes at least a certain amount of experience in its actual practice. Nor is it humanly possible for a physician to have mastered not only the medical discipline and psychoanalysis, but all of these allied fields as well.

As so often happens, therefore, one finds one group of social considerations balancing against another group. What may be scientifically valuable may be socially ill-advised; and as a result it is difficult to reach any universally applicable conclusion as to the best social policy to pursue. Accordingly psychoanalytic institutes in different countries are adopting somewhat varied policies in this matter, in response to the special problems and customs of their own lands. Where, as in this

country, medical practice is having to struggle against the invasion of all kinds of non-medical cults into the medical field, there is a strong tendency to rule out every non-medical person from any form of practice, and to make no exceptions at all. On the other hand, where no such fight need be waged the community can afford to be more generous in its attitude towards the lay-psychoanalyst; provided, of course, that the lay-practitioner subjects himself to exactly the same rigid training requirements as that to which the psychoanalytic institutes subject the physician.

Policy Guided by Varying Local Needs

Most psychoanalytic institutes have a provision, at least in principle, for training a few hand-picked laymen, demanding of them a Ph.D. as equivalent to an M.D. degree. In many communities, however, because of the local situation, and because of the importance of coöperating with the medical committees which are trying to stamp out the abuses of non-medical practice, these provisions are not being put into practice, or else laymen are trained only in theory and not in technique.

Ultimately it may be possible to make a clear legal distinction between, on the one hand, the non-medical psychoanalyst who has been thoroughly trained, and who in every way is prepared to coöperate with physicians, and, on the other hand, those so-called "clinical psychologists" who are untrained in psychoanalysis and who evade the rigorous exactions of a full medical curriculum.

CHAPTER X

THE APTITUDE FOR PSYCHOLOGICAL WORK AND ITS RELATIONSHIP TO THE EXPERIENCE OF PERSONAL SUFFERING

PSYCHOANALYSIS has focussed its attention on the investigation and relief of the varied forms of human discontent. It is not strange, therefore, that many of those who become interested in this discipline should be drawn to it by their own struggles with unhappiness. The advent of psychoanalysis brought an instrument of scientific inquiry to the study of an age-old problem.

The Relationship of an Early Awareness of Unhappiness to Psychological Insight

Although in general it is true that severely neurotic individuals are usually much preoccu-

pied with their own feelings, it is not true that *all* those who become conscious of emotional difficulties in their own lives are necessarily "more neurotic", or that they have more difficult or less soluble problems than those who seem more stable. Frequently the difference is chiefly in the age at which difficulties make themselves felt. Few human beings go through life without one period or more of turmoil. For some the struggle comes early, but may be resolved early. For others who start out in life with an air of perfect balance and adjustment, the difficulties may merely be deferred. It is a fallacy to think of the pseudo-normality of the early years of such individuals as a standard of healthy adjustment.

Thus there are people whose neurotic mechanisms manifest themselves early and quickly subside, either spontaneously or else with treatment. There are others whose neuroses appear early and never resolve. And there is yet a third group who seem more stable at the start of life, but whose neurotic manifestations are merely deferred to the later thirties or forties. These are important differences in time, but not in kind.

From the point of view of psychiatry it is fortunate that there are always some of those who early in life come to think about their own capacity for happiness and unhappiness, and to wonder with Thoreau why all men lead lives "of quiet desperation". These individuals, who openly acknowledge and attend to their inner moods, become what is called "psychologically minded". It is natural that those who make it their profession to study the problems of human discontent should come largely from this group.

External Factors that Aid in the Early Unmasking of Unhappiness

There are many factors which determine for any man when in the course of life he will face his emotional problems, if at all. Among these factors the external situation often plays a determining role. The struggle with feelings of helplessness and inadequacy, with fear and frustration and anger, begins for all alike in the earliest months—long before there is any awareness of variations in the external environment. But in the later management of that struggle the feelings emphasized by the ex-

ternal situation count increasingly. Advantageous and reassuring circumstances tend to quiet the conflict—as, for instance, wealth, membership in a dominant group, unusual prowess, great beauty, special talents, etc. Conversely, disadvantageous circumstances keep the conflict alive, and particularly if they are circumstances which seem to condemn a man because of his origins.

To men their origins are special sources of reassurance or of trepidation. To come from "important people", to belong to a "great" nation, to have an illustrious ancestor, is in most instances a prop. To come from a group upon which most of the world frowns, stirs smouldering self-doubts in all but the most stable. The human being usually feels some uneasiness when he goes beyond his group. A man who advances his station in life, however legitimately, tends to feel that his ladder is insecure. If he does react defiantly, he may try to hide his origins, by changing his name or his faith or his country or his home. Thus he pretends to himself to "belong", in order to escape that exacerbation of his self-doubts that occurs

through his identification of himself with his own submerged group.

The Position of Alien Groups such as the Jew

That is why members of all alien groups find that the petty difficulties which they encounter, even under fortunate circumstances, tend to exaggerate and confirm their more individual feelings of insecurity. As a result, their methods of masking pain are likely to become inadequate; and they come to live more openly in the consciousness of their problems. This may make for emotional instability; but when directed into productive channels it can also serve as a spur for intellectual, artistic, and economic productivity. This accounts in part for the importance of artists of continental origins in any Anglo-Saxon community. Furthermore, in any alien group, the intensified struggle with inner problems gives rise to a more than ordinary interest in the fields of psychiatry and psychoanalysis.

Is Psychoanalysis Therefore a "Jewish" Science?

Although this process of selection operates for all alien groups, it is peculiarly active in the case of the Jew in certain communities. This fact, and the fact that Freud himself is a Jew, has raised the question of whether or not psychoanalysis should be looked upon as a "Jewish science", i.e., a system of ideas which bears the stamp of a particular theological or social group. The question itself could scarcely be raised in earnest about any other scientific theory. The theory of relativity is not "Jewish" because Einstein is a Jew. If a Christian mathematician uses the theory in computing some problem, his answer is not Jewish. At least by analogy, then, psychoanalysis is not necessarily "Jewish" merely because Freud is a Jew. Of greater moment, however, is the fact that in its essence psychoanalysis is not a body of doctrines, but a technique which is applied by human beings to the problems of others. The majority of those who apply it are not Jews. Furthermore, psychoanalysis uses as its chief implement the method of free association, which long antedates Freud, and which was

investigated in other connections and used extensively before Freud by psychologists of many lands and many faiths (Wundt, etc.).

The Jew in Analysis

The practice of psychoanalysis demands only a proper training and a psychological bent. It finds this in every sphere of life, and in every racial, religious and social milieu. In no country is the practice of psychoanalysis a predominantly Jewish activity, although in a few centers of population the number of Jews among the members is high. The most that can be said is that as long as the position of the Jew in the world retains its present anomalies one may expect to find him consciously attentive to his own inner struggle and turning from that to a concern with the inner needs of others. Just so long, therefore, will he continue to play an eager role in the development of psychiatry and psychoanalysis.

CHAPTER XI

THE PATIENT AND HIS PSYCHOANALYST

The Choice of a Psychoanalyst

It is often asked whether it makes a difference to which psychoanalyst a patient goes, or whether the same results are achieved no matter who guides the treatment. Behind this seemingly theoretical issue lies a question which is of immediate practical importance to a prospective patient: "How can I be reasonably sure of getting into the hands of the analyst who will be the right man for *me?*" This question must be answered as fully as possible.

Training

In the first place, as is explained in Chapter 9, it is essential to ascertain whether or not the physician proposed as analyst is a member of an accredited psychoanalytic society, because at present this is the only way in which the

activities of untrained people or charlatans can be eliminated. That there are differences in skill between various members of such a society is inevitable, just as there will be between the members of any accredited society of surgeons. Furthermore, opinions will differ in estimating the relative skills of various members. Here, therefore, one can be guided only by the best available advice of other physicians and of friends who have had contact with individual members. Minor differences in skill, however, will have less influence than is popularly supposed on the success or failure of the treatment.

Personality

Assuming, then, that only men who have been adequately trained are considered, the question still remains: "What of the psychoanalyst's personality—what effect, if any, will that have?" Here one may draw a helpful distinction between, on the one hand, the facilitation of the *initial phases* of the analysis, and, on the other hand, the ultimate results. In the initiating steps and early phases of the work the analyst's voice, manner, appearance, acci-

dental individual peculiarities, sex, etc., will all call forth their own specific reactions in the patient. As a result, with one analyst the beginning of the ascent up the mountain will proceed by a different path from that which would be followed if another were the guide: issues will arise in different order; obstacles will therefore be surmounted in different sequences. Nevertheless if both hypothetical analyses were conducted by adequately trained men the ultimate view from the top should be the same, however much the paths up the mountain may have differed.

Sex of the Psychoanalyst

Usually this is true even of the sex of the analyst; so that under ordinary circumstances the sex may be disregarded. As with the personality, it may make a marked difference in getting the analysis under way and in the order in which the patient's material comes to expression, but not in the ultimate outcome. Whatever the actual sex of the analyst, the patient's phantasies will treat him sometimes as one and sometimes as the other. Therefore the naïve idea that *all* men patients should go

to men analysts and *all* women patients to women need be given little serious consideration. For certain special psychosexual problems, however, the sex of the psychoanalyst sometimes becomes important. Here the patient should be guided by the advice of the psychiatrists and psychoanalysts who are originally consulted. Occasionally the analyst himself finds it advisable in the course of the work to shift a patient from himself to an analyst of the opposite sex, in order to facilitate the elucidation of some resistant aspect of the patient's problems. This involves a temporary loss of momentum in the work, and a short period of recapitulation; but it is always a surprising experience to see how quickly the two pieces of work fit together.

The Analytic Incognito

The next point to stress is the necessity of going to a psychoanalyst who, aside from his professional reputation, is personally unknown to the patient. Everything which has already been discussed in the chapters on the technique of free association and the work of the analysis

(Chapters 4 and 5) should make clear the reason for this essential rule. The conscientious analyst will refuse to analyze not only his own friends and relatives, but even *their* intimates, because these would undoubtedly learn a great deal about him from overhearing casual conversations, etc. For them he can act only as a guide to direct them into the hands of others. The man who exploits his friendships to increase his practice violates a fundamental principle and makes the work of the analysis incalculably more difficult *for his patient.* Analysis is hard enough under the best of circumstances. It is not fair to the patient to place avoidable obstacles in his path.

The major responsibility for enforcing this rule falls on the analyst, because to a prospective patient it will seem easier to begin work with a man who is already known and liked. The patient is not in a position to foresee the added difficulties which this places before him. Therefore it is the psychoanalyst's duty, both as a physician and as friend, to select a psychoanalyst who, as an individual, is virtually unknown to the patient.

Concurrent Treatment of Patients Who are Friends or Relatives of Each Other

The same considerations must be weighed carefully whenever the question arises of treating concurrently or in close succession two intimate friends or two members of a family. Here no unvarying rule can be laid down; but it is essential that the analytic work should not be confused by competitive jealousies, and that the analytic incognito be preserved as scrupulously as is humanly possible.

Casual Contacts with the Psychoanalyst

From what has been said it follows that throughout the course of the treatment the patient and the analyst should avoid casual contacts outside the analysis.

The Austere Code of the Psychoanalyst

It may be noted in passing that the conscientious psychoanalyst must obviously make many sacrifices, both social and pecuniary, which others of the medical profession are not called upon to make. During an analysis he is not free to expand his practice by free contacts with the friends and relatives of his pa-

tients in the way that is entirely proper for other physicians. He must subject his personal advantage to the needs of his patients, and practice medicine with a more austere code than is necessary for his colleagues.

CHAPTER XII

THE RELATIONSHIP OF THE ANALYSIS TO THE PATIENT'S LIFE DURING THE COURSE OF THE TREATMENT

Analyst or Guide

Experience has proven that it is rarely possible to be guide and analyst simultaneously. For many reasons one finds that the more freely one offers advice, the less spontaneous and the less "free" become the patient's associations. In his role as guide the analyst would inevitably reveal himself as a real person, his standards, his tastes, his attitudes. He would become mixed up with the patient's own conscience; and the patient's thoughts would color from this. The analyst would lose his analytic incognito, and the patient the essential psychological freedom of his

associations. To the extent to which this occurred, the material would be deprived of some of its value as a clue to the patient's unconscious. Furthermore, towards the analyst as guide and towards such an analysis the patient will ultimately react with all the lurking rebellion against authority which secretly or openly characterizes all childhood. In compliant phases of the work this rebellion may be masked; but this sham compliance is likely to give rise to a simulated improvement which will break down as soon as the more independent and resentful aspects of the patient's problem reassert themselves. There is, of course, the obvious concurrent danger of limiting the patient's ultimate independence. Therefore the psychoanalyst cannot often give the patient active advice and guidance without impairing his analytic value; with the result that, in general, one aims at an analysis in which wise decisions grow spontaneously in the patient as a gradual product of the analytic work, and with a minimum of advice from the analyst.

Obviously, where a patient is too sick to be

entrusted with freedom to make decisions for himself, or where there is a strong tendency to any dangerous acts, someone may have to serve as counsellor and guide, or even as a custodian. In most cases much of this function had best be carried out by someone other than the analyst. Sometimes this should be someone entirely independent, sometimes the family physician working coöperatively, sometimes a nurse under the analyst's direction. In general it is best for the analysis when the analyst can divorce himself completely from all such direct control of the patient's life.

The Basis of Active Interference During Analysis

All such general rules must sometimes be broken, however; and when for any reason this becomes necessary the analysis suddenly finds itself interfering directly or indirectly with a patient's life, his habits, and his relationships with people. This occurs chiefly in the service of two fundamental but little understood requisites of successful treatment: i.e., the need to accept deprivation and the need to face anxiety.

The Principle of Deprivation

In the treatment of neurotic problems easy victories never last; and after beginning his treatment every patient must be prepared to face a long period in which his chief gratification will be his growth in understanding. This fact demands of the patient a certain ability to wait; and the patient who cannot tolerate deprivation even to this extent, who demands quick results and immediate gratifications, cannot be psychoanalyzed unless this attitude can first be altered. Indeed so important is this principle of deprivation that the psychoanalyst must sometimes intervene actively so as to cut off even normal sources of satisfaction in the patient's life, in order to force the patient into a state of active want.

That same school of Russian physiologists which unwittingly gave to psychoanalysis the experimental proof of the validity of the method of free association, furnished valuable support for this fundamental principle as well. *They demonstrated that it is only in a state of craving that important new connections can be formed in the central nervous system. The psychoanalytic version of this fact is Freud's*

observation that an analysis makes progress only in the presence of deprivation. Therefore when there is no fundamental deprivation already active in the patient's life, the analyst must introduce it. The form of this deprivation or abstinence varies with every patient and in different phases of every analysis. For one person it may mean living away from home; for another giving up reading or the movies; another may have to take a vacation from work; a fourth may have to stop even moderate drinking; a fifth may have to avoid friends. What is cut off will depend on which activity has been most used as an escape from inner problems.

To apply the principle skillfully, without being either too lenient or too severe, is difficult. More, perhaps, than any other analytic maneuver it puts to the test the analyst's own normality, his analytic understanding of his own unconscious, his freedom from anxiety and from unconscious resentments. Furthermore, whenever the analyst intervenes actively in a patient's life, he finds that the practical consequences involve not the patient alone, but also all those with whose lives the patient's life

is interwoven. For this reason, if for no other, it is well to explain the matter in some detail; otherwise one may find one's self warring with a well meaning but mystified and resentful family.

Discovering Hidden Anxieties and Symptoms

In addition to the principle of deprivation, there is a second legitimate basis for active intervention in the daily life of a responsible adult patient—*namely, the need to uncover anxieties or other mood disturbances which without such intervention might remain masked.* In this respect a psychoanalytic treatment can be likened to a fox hunt, in which the neurotic aspect of the patient is running from one cover to another, seeking to hide all revealing symptoms and moods. It is characteristic of psychiatric patients that they frequently try to prove that they are better off than the doctor, their friends, or their families would have them realize. Patients may come to their initial consultations only to find themselves compelled quite unexpectedly to make light of the very difficulties which have brought

them; and the same inner compulsion may continue to operate recurrently throughout the whole course of the treatment. To the analyst they may attempt to minimize real and painful emotions, while trying at the same time to dramatize them freely to their friends. Often, therefore, the psychoanalyst has to dig out the elusive evidences of illness from a frightened and evasive subject. Unless he succeeds in doing this the patient may fool himself or his friends or the analyst with an illusion of health which, although it may endure only as long as the treatment, will nonetheless frustrate all efforts at lasting therapeutic intervention, whether psychoanalytic or otherwise. Again it must be emphasized that without a full-hearted acknowledgment of the sense of illness a patient can go through only the motions of treatment.

The Non-Sedative Role of the Psychoanalyst

Certain implications of this are of great importance. Other physicians may play a pacifying, reassuring, comforting role towards their patients. The psychoanalyst, on the other hand,

when he believes that he is dealing with a patient for whom it is possible to achieve a fundamental and lasting cure, must do just the opposite. He may be as tactful and judicious as possible in the administration of pain, but in the end he must be merciless in hounding the neurosis out of every false cover. Indeed, just as he must sometimes intervene actively to produce situations of deprivation, so, too, he often has to tumble the patient into those very situations which arouse his neurotic fears, rather than shield him from them.

The Intervention in Outspoken Symptoms

In certain conditions the necessity for this is so clear that even the most casual onlooker can understand. It is self-evident that at some point in the course of his treatment a patient with a phobia of high places must be encouraged to go up to face his fear; or that a patient with a handwashing compulsion must relinquish his ritual no matter what anxiety this may cost him, etc. In executing such maneuvers the analysis meets with no objections from the onlookers. On the contrary, these have had to endure so many inconven-

iences from the patient's symptoms that if they hear of the analyst's ruling they welcome it with grateful approval.

The Futility and Danger of Premature Interference with Long-Established Symptoms

The case is similar whenever the patient has had outspoken symptoms, which have made his living obviously eccentric and unhealthy, and with which the psychoanalyst must interfere at some time. Usually, however, even in such clear situations, there is a long preliminary period before any prohibitions can be given. For it is not only the psychoanalyst who must come to know the meaning of the particular symptom or of the disturbing way of life; before successful interference is possible this knowledge must have become something which the patient, too, has at least begun to understand. Through many months of work, therefore, every symptom must play its part in the analysis, just as it has previously existed in the life of the patient. As one man has put it, the soldier who never goes into battle never gets killed: and the symptom that never ap-

pears actively in the analysis never gets analyzed.

During this long period of waiting the onlookers may well become impatient and critical. It is then that they begin to say, "Why doesn't he *do* something? Why doesn't he stop that? What good is all this talking, anyhow?" To this the only possible answer is that premature interference not only is foredoomed to failure, but also prejudices the value of all later active intervention. Therefore the wise psychoanalyst waits as patiently as a wise brain surgeon; and it is equally fatal for either to allow himself to be influenced by the impatient "common sense" of family or friends.

The Unmasking of Unrecognized or Disguised Difficulties

Unfortunately the task of the psychoanalyst is not often confined to maneuvers the wisdom of which is as evident to the onlooker as in the situations outlined above. Frequently the patient's problems lurk behind seemingly unrelated details of his life. Where these involve no one but the patient, the work of the analysis deals with them without reference to the out-

side world. Thus no one but the patient and his psychoanalyst is aware that anything has happened when some minute detail of a patient's habitual ways of sleeping or eating or dressing has been altered in the effort to unmask obscure anxieties.

Isolation During Analysis

It is another matter, however, when important human relationships or the patient's very life-work must be interfered with. It is not easy for old friends to find themselves even temporarily out of contact, much less for those members of the family or those physicians who may have spent many years in intimate concern for the patient's health. Yet the analysis must often act as a wedge temporarily dividing the patient from all these influences; and to those who are excluded this looks like ingratitude and eccentricity—just another sign of the absurdity of the whole procedure. But the good intentions of these well-wishers have little to do with the use which the patient makes of their loyalty. It is as impossible to create self-sustaining health for a patient who is constantly being propped up, as it would be

to strengthen a limb in a splint. For this reason, if for no other, *it is often necessary during an analysis to lead a patient through a sustained period of relative isolation from his usual activities and human associations.*

Ultimately, of course, the successful analysis will lead the patient back again into renewed and clearer relationships to all those whose intimacy has stood the test of analytic scrutiny, and where the basis of the relationship on both sides has proved to be fundamentally normal and not neurotic. The path to this goal is long and tortuous, however, and demands an unusual degree of patience and confidence.

The Neurotic Exploitation of Normal Life

Sometimes it may even become essential to the progress of the analysis to take a parent temporarily out of his home, or a man from his work. This may become necessary just because men hide their emotional difficulties, making their lives endurable by balancing their weaknesses and masking their anxieties through a species of unconscious exploitation of relatives and friends, of work and play. One by one the psychoanalyst must strip away these

obscuring devices until the difficulties they shelter stand revealed. If these devices were always in themselves abnormal or unnatural there would be relatively little difficulty about this essential maneuver. But unfortunately a patient is likely subtly to invest the most normal aspects of his life with his neurosis. What one man hides in compulsive drinking another man may hide in an excessive work drive, or a woman in hyperconscientious preoccupation with her family and children, or in bridge, or philanthropy or society. Obviously no one will doubt the wisdom of interfering with the habits of the drinker; but it will seem strange to interfere even temporarily with the others. Nevertheless, where practical considerations make such an interference impossible, the analysis may be seriously hampered.

The Refusal to be Deprived. Love Affairs. Wealth

The ideal analytic situation is that in which the patient can be brought to see the need for this type of self-denial and puts it in force of his own accord and without active pressure from the psychoanalyst. The most difficult

problems arise whenever a patient persistently evades all such deprivations, and refuses to face anxiety or pain in any form. This, indeed, is one of the factors which make a successful analysis in the face of a love affair, or in the face of great wealth, peculiarly difficult. No human being accepts deprivation easily; and where the consolations of love or wealth are easily available it takes a patient of exceptional stamina to turn his back upon them. It is characteristic of analyses of the affluent that they are suddenly broken off or interrupted by impulsive self-indulgences—a trip to Florida, a hasty marriage, a hunting trip, etc. One unfortunate man who sought help for attacks of overpowering anxiety refused to be analyzed because his wife was disappointed on learning that he would be unable to accompany her on their frequent hunting and fishing expeditions.

An analysis, therefore, may from time to time become involved in a struggle against a patient's methods of garnering momentary pleasures with which to mask his moods of fear, anger, depression, and the like. *In the effort to unmask hidden difficulties the psychoanalyst*

must at times block even healthy outlets of work and play, while at the same time, and paradoxically, allowing a patient to skirt danger or even to flounder into it if there is no other way to prove to him the neurotic basis of his conduct.

The Essential Conflict Between the Needs of the Analysis and the Immediate Desires of the World Outside

That little world which circles around the outskirts of every analysis finds it hard to understand any of this. Its purposes are often directly opposed to the needs of the analysis. It is always trying to reduce the tensions which the analysis must often inflate. It is outraged in those phases of the work in which the analysis may be isolating the patient from daily realities—from work, family, friends, society, or play; and it may be equally perplexed at those other moments in which it becomes essential for the patient to have the closest possible contacts with all these situations.

Similarly this small world always hopes that the psychoanalyst will intervene quickly to cut the patient's Gordian knots. In contrast to

this "practical" point of view, when a patient gets into a state of obsessional indecision, whether it be over buying a hat or contracting a marriage, the analysis tries to defer all impulsive pseudo-solutions of the problem. At such a juncture, to postpone acting may take courage and the ability to stand deprivation and uncertainty; while the tension thus mobilized pushes into the foreground all the unconscious forces out of which the paralyzing indecision has arisen. Therefore the psychoanalyst must turn a deaf ear to the importunities of the outside world when it says, "Oh why doesn't he tell him what to do—he must know by now—it would be better to do *anything* just to get the suspense over".

The Special Case of Children and Psychotics

Again we see that in dealing with an adult patient whose illness does not make him irresponsible the psychoanalyst cannot play the role of guide and protector without masking the very problems which it is his primary function to uncover. Important plans and decisions may grow out of the analytic work; but except

as a temporary measure they cannot be imposed by the physician if he has his patient's ultimate *independent welfare* at heart. It is only in dealing with children, or with psychotic patients who are not fully responsible, that the psychoanalyst either must take on this double role, which may seriously hamper his analytic function, or else he must turn over to others the custodial care and guidance.

The Problem of the Impulsive Patient

Patients who are otherwise responsible, but whose neurosis leads them constantly to skirt the edges of dangerous situations, constitute a peculiarly difficult problem. They are the causes of most of the accidents which may occur during the course of psychoanalytical treatments; and in dealing with such patients the psychoanalyst assumes a grave and anxious responsibility. He courts disaster if he does not interfere; but if he interferes he jeopardizes his fundamental therapeutic aim. Between the two the choice is sometimes extremely difficult; but the choice must be his.

CHAPTER XIII

THE RELATIONSHIP OF THE OUTSIDE WORLD TO PATIENTS UNDER ANALYSIS

The Patient's Self-Protective Secrecy

Patients often begin an analysis determined to tell no one of their plans. Sometimes this is because they realize that if they took anyone at all into their confidence the news would gradually reach the ears of others who would try to interfere. They wisely wish to avoid being drawn into futile arguments at a time when undivided attention is needed for the analysis itself. In such cases secrecy, at least until things are well under way, is the only sensible plan. Secrecy, however, often arises from a sense of shame. Because he fails to realize how nearly universal are these difficulties, the layman still feels deeply mortified

at any public acknowledgment of his need. He may feel this even when every friend and relative is fully aware of his condition; and thus one sees the sorry spectacle of a patient trying to hide an illness which everyone has long since recognized, by refusing or hiding the treatment which all who care for him are longing to see him undertake. In a successful analysis such shame as this will gradually be resolved.

Frequently, moreover, the patient who from the outset resolves to keep secret his analysis does so because his own doubts of the wisdom of his plan are so active that he cannot bear to encounter any answering skepticism in others. In any case, as the analysis proceeds and anxieties lessen, friends and relatives gradually are taken into the patient's confidence. Thus a little world of interested spectators slowly gathers around almost every psychoanalytic venture. The behavior of these onlookers, individually and collectively, makes at times a good deal of difference to the comfort of the patient and to his freedom from distracting external influences.

The Right to Reasonable Protection

The patient has a right to a decently respectful attitude of non-interference. Any kind of hot-house protection for psychoanalytic patients is neither possible nor even desirable; but it should be remembered that all patients whose work means anything to them must go through repeated periods of intense emotional sensitivity. It was no act of kindness for a keenly observant friend to call across a formal dinner table, "I can't believe you're having an analysis for the reason most women do. You're young. You're attractive. You're not in love with someone else, are you? Your husband is such a grand person, you can't be out of love with him"!! How could she answer such an attack? How could she tell him of the years of misery which she had always kept hidden? Nor was that other "friend" very considerate who said, "Darling, I hope you're enjoying a perfectly lovely transference", to a patient who was in a turmoil of confused rage and hope and fear in her attitude to the psychoanalyst. The hurtfulness of such comments is scarcely bearable at times; yet they are the all-too-frequent experiences of all patients. One can only plead

for a patient's right to be left in peace to work out his problems.

The Over-Solicitous Friends

Much less gross, but nonetheless disconcerting, may be the solicitous inquiries of respectful and interested friends. "What are you getting out of it? Is it proving worth while?" are legitimate questions for a patient to ask himself at various points along the road and again at the end of the way. But an outsider has no way of gauging into what distressing phase of the work his question may fall. Nor can he be aware of the impossibility of answering such a question, except by reassuring generalities or evasions. The wise patient is rarely willing to divulge to such well-meaning friends the intimate personal difficulties which can be profitably shared only with the psychoanalyst.

The Neurotic Exploitation of Friends as Allies

Sometimes this little world of interested and curious spectators is drawn into the struggles of the analysis by the patient himself. Not in-

frequently a patient who consciously or unconsciously wants to sabotage the analysis builds up two groups of allies: in the one group those who support the analysis, and in the other the skeptics. Such a patient, according to his mood, finds himself associating now with one circle and now with the other; and quite unwittingly and in all good faith even within a single day may give to members of each group completely opposing pictures of what is going on in the analysis, leading them on into contention and disagreement and a turmoil of conflicting counsel.

This may begin with the first analytic session. Recently a patient who had come to analysis eagerly, and yet with a deep reluctance, resolved to tell no one about it. Nonetheless she left her first session to make an unpremeditated call on a relative in whose presence she made a slip of the tongue which betrayed the fact that she had begun an analysis. This relative was the one person who was most certain to oppose her analysis bitterly.

In each recurring period of difficulty in the analysis such things are likely to happen; and it is a rarely fortunate patient whose friends

and relatives refuse to allow themselves to be drawn into the struggle but who say to the patient, "Keep your confidences for your analysis and work out the problem there".

The Patient's Need for Periods of Isolation

One might summarize as follows the patient's need for periods of isolation from his family and friends: (1) because so frequently these relationships have been invested with all the neurotic difficulties of the patient, (2) because they are used so often as a focus for his symptoms and difficulties, (3) because symptoms and difficulties tend to suffer acute exacerbations when the patient is in his old setting, (4) because on the other hand he may use friends and relatives as a method of covering and escaping from the difficulties which the analyst is eager to bring to the light, (5) because friends and relatives often have an oversolicitous concern for his welfare, and, knowing him well, can see too clearly the difficult phases which he may wish to hide from view as he is working through them.

On the other hand, it is often an act of kindness to the family and intimate friends to give

them a rest from their responsibilities and their intimate contacts with the patient. They have usually suffered a great deal through his illness. If they are attached to the patient they will feel unduly disturbed every time he goes through the necessary periods of symptomatic exacerbation and emotional distress. Furthermore, they may have been badly used by the patient because of his neurosis, and they may therefore have much hostility towards him from which it is well to shield him until well along in his analysis. All these considerations make it wise from time to time for the analysis to act as a wedge dividing the patient from his usual associations. When this happens, however, unless it will excite in the patient a dangerous amount of distrust and jealousy, the analyst must be ready to satisfy the misgivings of the responsible members of the family and to allay their anxieties as much as he can. Where, because of the patient's attitude, it is not safe for him to approach them directly, he must make this point clear to them through the family physician or some trusted representative.

CHAPTER XIV

THE RELATIONSHIP OF THE OUTSIDE PHYSICIAN TO THE ANALYSIS

The Method of Referring a Patient for Analysis

The selection of patients for analytic treatment implies the rejection of others for whom it is not the appropriate procedure. The basis of selection is, in detail, a technical matter into which we cannot enter fully (*cf.* Chapter 8). At times the decision may be so difficult, however, that in practice it is a sound precaution always to begin an analysis with a period of trial, deferring for some weeks the final decision as to its wisdom. It is for this reason that psychoanalytic clinics assign their most experienced leaders to the task of selecting and rejecting patients.

Since it is so difficult for the analyst to reach this decision, clearly the general physician

should be cautious when he urges a patient to consult an analyst. It is better for him not to refer the patient to a psychoanalyst "for analysis", but rather for consultation as to the desirability of an analysis. Once that opinion has been secured, the struggle to convince the patient of the necessity of the procedure can be undertaken without further hesitation. Otherwise the analyst sometimes finds himself in a difficult predicament, confronting a patient who has been persuaded that analysis is his only hope for health, and yet that patient may be one whom no analyst would attempt to analyze.

Why the Family Physician is Usually in the Dark

Why it is that during the course of the analysis even the family physician must sometimes be kept in the dark is a matter that is difficult for the onlooker to understand. It is a fact, nonetheless, that in many instances patients are most explicit in their demands that nothing of their symptoms or problems should be communicated even to the physician who has indicated his confidence in the psychoanalyst by sending the patient to him. For the psycho-

analyst this creates an awkward and unhappy dilemma; but his responsibility to the patient is paramount, and when this request is made he must accede to it. If in the course of the analysis it develops that the patient's request rests upon some neurotic distortion of his attitude towards the family physician, and if this aspect of the neurosis is satisfactorily resolved, the patient may withdraw the restriction and leave the psychoanalyst free once more to take the referring physician into his confidence.

Yet the patient's reluctance to have his story retold even to his family physician is not purely neurotic. The task of analysis is one of extraordinary difficulty. To expect a patient to unburden himself without restraint in the presence of anyone is to expect a great deal. To ask that he do so in the presence of *two* people makes the task almost impossible. Yet that is what it would be like if a psychoanalyst said to his patient not, "What you say here is for my ears alone"; but, "What you say here is only for my ears *and* those of your family physician". The patient's confident sense of complete and exclusive privacy cannot be violated even to this extent without running

the risk that he will be unable to achieve complete frankness. Even where the patient makes no specific request to the analyst not to discuss him with his physician, it is rarely profitable to tell the outside doctor very much. The family physician, for his part, has a natural interest in his patient, a scientific interest in the progress of the analysis, and even some frank curiosity. This is to be expected: but under usual circumstances his interest can be gratified only sparingly and in most general terms during the course of the analysis.

Medical Indiscretions

It should not be necessary to say that such a physician should obligate himself never to divulge any such confidences to anyone. However trivial they may seem, their significance to the patient may be surprisingly great; and it is literally fatal to have any fact, however minute, escape from the analysis back to the family or friends and thence to the patient. The particular fact may in itself be of no moment. It may be something which the patient himself may be ready to tell to anyone; but the fact that it escaped the analytic con-

fidence means to the patient, and rightly, that more important things might also leak out.

The importance of this warning cannot be exaggerated: and the temptation to minor indiscretions must be resisted constantly. The path may be tortuous, but it ultimately leads back to the patient with a fatal precision: as an actual example, from the psychoanalyst to the thoroughly trusted physician of the family, from him out of the goodness of his heart to comfort an anxious mother, from her out of her need to her "best friend", from the "best friend" as a warning to her daughter, from the daughter to her husband, from him to the patient's husband, thence to the patient, and from the patient back to the psychoanalyst. Well-meaning people are indiscreet in this way, not out of malice, but out of sympathy or the pressure of their own needs. Therefore *no one* but the analyst himself can be safely entrusted with the analytic secrets of a patient. This is not mysterious psychoanalytic cultism. It is a conclusion drawn from the experience of psychoanalysts in their dealings with the doctors, friends, and relatives of their patients; and it applies just as much to fellow-analysts as to

anyone else. Of all physicians, the psychoanalyst has the least right to talk of his patients to his colleagues without protecting meticulously the identities of these patients. A good analyst is always close-mouthed.

Physical Care During Analysis
Mutual Confidence Between Analyst and Physician

The patient throughout his analysis must be guarded adequately against the occurrence of physical illness. Rarely, if ever, will the psychoanalyst attempt to perform this function himself, lest it interfere with his value as psychoanalyst. Instead, at any hint of physical disturbances he will expect the patient to turn to his usual medical advisor. This necessitates a good working understanding between the two physicians, something which may be hard to achieve if the outside physician is hostile to psychoanalysis and doubtful of the integrity of all psychoanalysts. If this makes all understanding impossible between the two physicians, it may become necessary for the psychoanalyst to insist that the patient rely upon some less hostile medical advisor for the

duration of the analytic treatment. Fortunately, however, disagreements nowadays rarely come to such a pass except with extremely reactionary physicians.

Even with full coöperation, however, the medical advisor works at a disadvantage because the psychoanalyst can take him into his confidence only to such a limited extent. Nevertheless where a serious problem arises as to the organic or psychogenic nature of some symptom that appears during the analysis, the two must be able to confer without the usual reserves and thus to arrive finally at a point of view which does justice to both possibilities. Unresolved differences will only perplex the patient and not help him.

The Patients' Varying Attitudes to Medical Treatments

Again, where the patient is one of those who retreat into real or feigned illness at every emotional strain, some mutually acceptable attitude must be found by the two physicians. Otherwise the patient will play one off against the other with a disastrous effect upon the ultimate therapy. Whenever, with any patient,

it becomes clear that such recurrent episodes of illness conceal no serious physical condition, it may become necessary to forbid him to seek medical advice of any kind for a time. This, however, would best be done with the sanction and support of the medical advisor.

A contrasting condition also is encountered, in which patients cling to organic illnesses, hiding even distressing symptoms, giving evasive and conflicting descriptions of them, and resisting the utmost pressure which the analyst can exert in an effort to force them to seek help from their usual medical advisors. Where such an impasse arises early in an analysis it is difficult to deal with, and may even force a premature interruption of the work. At a later stage it will usually be possible to eliminate the obstacle by analyzing it to its unconscious motives.

The relation of physical illness to emotional processes is far more complex than this brief note might suggest. It leads, however, into many unsolved scientific problems and therefore would best be left out of the scope of this discussion.

CHAPTER XV

PSYCHOANALYSIS AND MARRIAGE

TO THE solution of marital problems psychoanalysis can make a definite contribution by uncovering the sources of unconscious hostility and fear, and by clarifying their manifestations in the marriage. In this way it can lessen or eliminate their effects.

The Varied Forms in Which the Problem Presents Itself

This usually takes the conjoint action of both the husband and the wife, however; and all too often, before they reach the analyst's office, the hostility has become too outspoken for any such mutual effort. The situation is ideal where both come for help; but on the whole this is still the exception. More often one or the other comes secretly, or in fear, or defiantly, and against the other's wishes, or else half reluc-

tantly and resentfully and with protests. There is thus a wide variety of forms in which the problem presents itself to the analyst.

Patients may come in a state of concealed panic, without realizing at all that it is the marriage which is threatened. They may try indirectly to strike a bargain with the psychoanalyst, "You may analyze me if you will promise not to uncover any sources of unhappiness in my marriage". Or they may come with a purpose that is the exact reverse of this, trying to blame purely personal problems on the marriage, and seeking a pseudo-psychiatric, pseudo-psychoanalytic justification for promiscuity or divorce.

Sometimes a patient will seek help in a crisis in which the difficulty is caused largely by the illness of a partner who refuses to acknowledge his illness and his need for treatment. The partner's symptoms may be as obvious as chronic alcoholism, frank sexual perversions, or fully developed anxiety states; and still he may refuse to consult a doctor. The one who comes for advice may have shielded the other loyally for years, so that no one may have

known of the difficulty; until the increasing strain and the incessant threat to the welfare of the children finally compelled action. It is not uncommon, then, for the healthier of the two to ask to be analyzed, hoping that by some trick of super-adaptation, some magic of absent treatment, the sick one may be cured without the direct treatment which he rejects.

Other patients come for analysis resentfully and only under the threat of divorce or separation; and still others may seek help earnestly, but in the face of bitter resentment and neurotic jealousy on the part of the wife or husband.

In the presence of such obstacles it may be difficult to decide whether or not to undertake an analysis at all. After the analysis the outcome of the marriage must depend at least partly upon the ultimate attitude of the unanalyzed partner as well as upon the patient. Healthy adaptations can never come exclusively from one side.

The Spread of Psychoanalysis Through a Family

Occasionally, however, even in seemingly hopeless situations, the gradual improvement

in the patient may slowly break down the opposition of the other, and lead him too to seek help. Where this can take place the outlook becomes more hopeful. To the onlookers, who have never been allowed any hint of the struggles through which the couple was passing, this spread of psychoanalysis through a family often arouses cynical comments. Nevertheless, to many a couple it has meant the difference between peaceful health together and divorce.

The Choice of Marriage or Health

It must be remembered, however, that psychoanalysis is aimed primarily at the preservation or restoration of mental and emotional health. The psychoanalyst is not a marriage broker, nor a marriage saver, nor yet a marriage wrecker. Whenever the issue comes clearly to a choice between health or marriage, his medical duty and obligation is at the least to present this issue clearly, so that the patient can make his choice in full awareness of its implications. Happily, such an impasse arises much less often than is popularly believed.

Psychoanalysis and Divorce

Exaggerated Idea of Frequency of Divorce After Analysis

The world at large has an exaggerated impression of the frequency with which psychoanalysis ends in divorce. Marital conflicts, like other neurotic symptoms, are usually hidden as long as possible. As a result, although the pot is usually boiling long before it is brought to the psychoanalyst for him to cool, no one except the husband and wife who are directly involved may have had any suspicion of the extent of the maladjustment. Such cases, when they finally reach analysis, may have gone too far along the road to divorce for any successful analytic intervention. This is one of the reasons why it is often thought that analysis always ends in the disruption of a marriage.

Another reason for this same impression is that where the analysis succeeds in resolving the marital difficulties, no one may know either that the marriage has been threatened, or even that the husband or wife has been undergoing treatment. *Therefore one hears more gossip of failures than of successes. Divorce has the greater news-value.*

Occasional Inevitable Divorce

On the other hand it is true that divorce sometimes is inevitable. This is due to the fact that marriage so often becomes the focus of all the neurotic disturbances to which the husband or the wife is subject, with the result that the relationship between the two may have been battered for years before their problems were brought to a psychoanalyst. By this time, even the restoration of health may not be enough to take the sting of bitterness and defeat from the hearts of the two patients. Divorce, therefore, may be chosen in the end even despite the successful analysis of the neuroses which led up to it.

Neurotic Marriages

The unhappy and inescapable truth is that many marriages are contracted on a basis not of health, but of neurotic purposes. The picture is all too familiar of maladjusted young people who try to escape their separate miseries by joining their problems in marriage. Where the marriage fails to cure the misery, in the end it is usually blamed for it; and presently the

neurotic aspects of both partners are pitted against each other in a merciless battle. If both get well through psychoanalysis, and if the battle has not gone on so long that all spontaneous affection has long since been supplanted by pain and hostility, the marriage, despite its neurotic origins, has a chance to run a new and happier course. Where, however, only one of the two consents to be treated, or if only one succeeds in achieving health, separation may be the only healthy solution.

The Popular Misconception

It is worth while to stop for a moment to consider how fundamentally this differs from the usual story of a marriage which terminates in a divorce during or after an analysis. The outsider never likes to admit that fundamental facts may have been withheld from him, especially if he is a close friend or relative; therefore he says, "They were perfectly happy until they went to a psychoanalyst who told them they hated each other and needed a freer life. Then they started running around and now they're divorced"

Divorce as a Criterion of Failure in Psychoanalysis

What, however, of the idea that any analysis which ends in divorce is *ipso facto* a failure? This is tantamount to claiming that the function of psychoanalysis is not primarily to cure people of their neuroses but to make them able to put up with all the neurotic mistakes which they have ever made. The psychoanalyst aims to save a marriage wherever this is humanly possible; and the frequency with which he succeeds in this bears testimony both to his purpose and to his ability. Where, however, he must choose between a patient's health and a patient's marriage, the issue must be squarely faced.

Psychoanalytic Preparation for Marriage

One cannot leave this topic without a look into the future, asking of it what effect upon marital happiness and stability the psychoanalytic influence in education will have, and the psychoanalytic treatment of young people who are in difficulties before they contract neurotic alliances. It is a question which the coming decades will answer. It leads one to

speculate hopefully about the potential value of psychoanalysis as a preparation for marriage.

Technical Problems

Concurrent Analyses of Husband and Wife

Of the technical problems which arise in the psychoanalytic treatment of marital difficulties, only two demand elucidation here. The first is the problem of the concurrent analysis of husband and wife. There can be little doubt of the value of this when the analyses are independently conducted by two psychoanalysts. Differences of opinion will be met with only as to the advisability of having one physician treat both patients at the same time. That any psychoanalyst would have a mercenary inducement to do this is obvious; but the practice is generally held to be unwise by most experienced psychoanalysts. Not only does it complicate the transference situation (Chapters 5 and 11), but, contrary to superficial expectations, it actually makes the task of both patients harder. In the end one or the other is sure to lose his confidence in the impartiality of the physician; and the analysis of this patient will suffer ac-

cordingly. Therefore, if it is necessary not to postpone the analysis of one until the other is finished, it is wise to send the second patient to another psychoanalyst.

Furthermore it is only rarely justifiable to hold up one treatment until the other is complete. It makes both the patient under treatment and the future patient uneasy—obscuring the important terminal phases of the analysis which is under way. The waiting patient presses for the other's analysis to be over so that he can begin; the other holds back. It is simpler and fairer to steer the second patient to someone else from the start. Cases of marital maladjustment which are not to be psychoanalyzed can sometimes be handled most effectively if both patients are treated by the same physician; but even here, if the currents of hostile feeling run strongly, it is often advantageous to seek the help of two physicians instead of one.

Technical Separations During Analysis

The only other technical problem which is of practical importance to others than psychoanalysts themselves is the problem that arises

when a patient has to work out both a personal neurotic problem of urgent intensity and a marital conflict. In such circumstances it may become extremely difficult to make headway without separating the two problems. To do this it is sometimes necessary to arrange a temporary technical and therapeutic separation, so that the personal aspects of the difficulty can in some measure be clarified apart from the problems of adjustment in the marriage. This is possible, of course, only with the understanding, coöperation and assent of both partners.

CHAPTER XVI

FINANCIAL ARRANGEMENTS

The Obligation of Frankness

It is the custom to pass lightly over the financial arrangements of the professional man and his client or patient, and to act as far as possible as though money did not exist, almost as though it were below the dignity of either to discuss money frankly. This polite pretence is particularly frequent in the dealings between a physician and his patients. It would not be possible, however, for the psychoanalyst to follow such a course, even if he should want to.

It is the psychoanalyst's task to clarify to the patient the way in which confused emotions may disturb even the most humdrum of daily affairs. Since emotions have a way of intruding themselves into all financial dealings, he cannot allow the patient to sidestep the emotional significance of money. Nor could the

patient and the analyst consistently treat with frankness all other money matters and at the same time dance a courtly minuet about the arrangements to recompense the analyst for his time. Indeed it is often in the patient's financial dealings with the psychoanalyst that it first becomes clear how unexpectedly complicated may be the emotions which money evokes. And, finally, the frankness with which this problem is handled is one indication of the integrity of the patient's purpose towards his analysis. Open discussion of finances is therefore not only a necessary preliminary step, but is bound to recur from time to time throughout the treatment.

The Unwritten Contract

The relationship of the psychoanalyst and his patient is in its essence an unwritten contractual obligation on both sides. The psychoanalyst obligates himself to treat a patient in return for a certain fee, and to remain responsible for the treatment until he feels that he has done everything in his power to help him towards health. The patient, in turn, obligates himself to be financially responsible for

the time assigned to him, whether he keeps his appointments or not, from the moment when he begins his analysis until it is either terminated or discontinued. In this respect, psychoanalysis follows a practice which is customary in certain other medical fields in which a specified hour is allotted to a definite patient for a definite treatment, and where unexpected blanks cannot readily be filled in.

Missed Sessions

Even where the patient announces ahead of time his intention to miss a session, the obligation to pay for his appointment usually persists. Otherwise the patient is given a double incentive to be irregular in his attendance. In the first place there is an ever-present temptation to run away from the analysis whenever things become difficult; so that, without a strong deterrent, minor business or social demands can be allowed to interrupt the continuity of the analytical work. In the second place, if the patient is not charged for missed appointments he is given a positive monetary incentive to absent himself, because not only can he then go off to enjoy a gay time, but also

he can save money as well. The steady continuity of analytical work is of such importance (*cf.* Chapter 3) that every inducement must be brought to bear on the patient to make him keep to his schedule in spite of the recurring impulse to break the work into discontinuous fragments. The rigidity with which one must adhere to this practice of charging for missed hours varies somewhat from case to case, and may vary in the same case at different stages of the analytical work.

Fixing the Fee. The Use of Income or Capital

In determining the psychoanalyst's fee it is necessary for the patient to present the full facts of his financial condition to the psychoanalyst. Together, then, they decide whether or not the analysis can be paid for entirely out of income, or whether it is fair to look upon health as a form of capital which would justify the use of a certain amount of monetary capital in paying for the treatment. In this connection it is well to remember that the psychoanalyst contributes working capital to every treatment, in that he obligates himself to contribute not

only knowledge, but also his time, which is his only irreplaceable capital goods. The time he devotes to one patient is gone and cannot be used for another. A similar sacrifice on the part of the patient, therefore, is not unreasonable to ask, where it is necessary, and where it does not jeopardize the patient's fundamental economic security.

Budgeting for an Adequate Period of Treatment

It is imperative also to keep in mind the duration of the treatment. Although it is impossible ever to predict ahead of time how long an analysis will take, it is a safe procedure to budget for two years of work, acknowledging the possibility that it may take less than that, and even more emphatically stressing the possibility that it may take longer. ***It is never justifiable for a psychoanalyst to fix his charges at such a rate that all of the funds available for a patient's analysis will be used up within a few months, when a lower fee would carry the patient through the treatment to a satisfactory termination.***

Who Should Pay for the Analysis?

It is often difficult to decide who should pay for the analysis. It is best when this sacrifice is made by the patient himself. Frequently, however, and especially with women and with minors, the patient may have no money at all, or very little, whereas the husband or guardian may have adequate resources at his command. In such cases the psychoanalyst must examine the patient's situation to decide whether or not some of these accessory sources may fairly be called upon to support the patient's treatment, or whether the use of some such accessory source of income will affect the treatment in any detrimental way.

For instance, on one occasion a patient who was part heir to a large fortune was treated for many months. He could have gone to his father freely for money. Nevertheless, because it was essential that this patient should undertake the treatment on an independent and self-supporting basis, and that it should be his personal sacrifice which made the analysis possible, he was treated for a fee that he himself could afford, i.e., what would ordinarily be charged a person of limited means. It must be

borne in mind, however, that when an analyst makes a reduction in his charges to a patient for whom large resources are indirectly available, he limits his ability to make concessions to patients who have no money at their command.

Borrowing from the Analyst or from Others

Sometimes a patient with prospects of future resources is justified in borrowing money to pay for the analysis. If such a patient fails to borrow, and the analyst must therefore treat him for little or nothing, in effect the patient either is borrowing from the psychoanalyst or receiving a gift. There are few psychoanalysts who can afford to play the role of banker; but even where they can, this situation may seriously complicate the analytic relationship.

In all these questions it must be obvious that there are few rules which will apply equally to all cases.

The Fee

Psychoanalytic charges vary widely. The same psychoanalyst may have at one time a patient who is paying him nothing, another

who pays five cents an hour, and another who pays twenty-five or thirty dollars an hour. There is no one "fair" charge. The psychoanalyst's apprenticeship and training take as long as that of the skilled surgeon; and the surgeon is often entitled to charge many hundreds of dollars for one hour of his operative skill. The surgeon, however, makes his charge only once, whereas the psychoanalyst must ask only what a patient can afford to pay every day for many months.

Whatever arrangement he makes must be based upon a plan which will enable the patient to finance himself throughout the analysis to its termination. It must take into consideration the source of the money with which the psychoanalyst is being paid, so that this in turn does not in any way hamper the progress of the work. And it must provide the patient with an opportunity to make some personal sacrifice for the analysis. To this end, where the patient himself does not pay the entire fee, he can be charged with the responsibility of some part of it.

Every psychoanalyst aims to achieve a reasonable, steady income from his day's work. It

is impossible for him to handle analytically more than a few patients and do any one of them full justice. From the varying fees which he charges these patients he attempts to realize a certain average return. When he has several patients who are unable to pay him more than a small part of this average, he is forced to balance this by reserving his other hours for patients who can pay him above this average. When, on the other hand, his list includes several patients whose incomes entitle them to pay average, or higher than average fees, he is placed in a position in which it is possible for him to work with patients for little or nothing. Almost every psychoanalyst, therefore, has one or two patients in this latter category. There are only a few who demand a maximum fee from all.

Free Analyses

In some centers it is the practice of the Psychoanalytic Society to exact a pledge from every member to accept one patient who is referred from the Psychoanalytic Institute for free treatment. In others, no such formal demand is made upon the members of the in-

stitute. Informally, however, much the same social contribution is made through the personal recommendation of such patients from one psychoanalyst to another on a voluntary basis. That is, a psychoanalyst whose schedule is full, or who cannot afford at any particular time to take on another free patient, helps such a patient to another psychoanalyst who at the moment is in a position to accept him.

Unfortunately, however, free analyses, or analyses which cost the patient little, may present peculiarly grave obstacles. Such an experience as the following is not an isolated example: A Mr. X applied for help in a difficult situation. In the course of the discussion it developed that the patient had come with the hope of beginning an analysis at once. The physician was unable to take the patient because his own schedule was full, but offered to suggest the name of another psychoanalyst. At this the patient confessed that he had almost no money with which to pay for an analysis. Nevertheless it was possible to arrange with an able colleague to undertake the treatment for twenty-five cents an hour. Instead of manifesting the kind of cöoperation which

one might expect, the patient fought the analysis at every turn; coming late and leaving early, skipping hours when other engagements occurred which made the patient fear that if he went to the analysis he might become somewhat upset. It would be a generous estimate to say that this patient put in a maximum of two hours per week of analytic work out of his six appointments. In the end it became necessary to break off the analysis. At this the patient's indignation at what he considered to be his unfair treatment led him to spread many a false story about a hard-hearted and unscrupulous psychoanalyst who dropped him because he had no money.

Average Fees and Average Costs

We have said that psychoanalysts may charge anything between nothing and twenty-five or thirty dollars a session. Rarely, in exceptional circumstances, an even higher charge than that might be justified. No statistical data is available, but a random guess would set an average fee for all psychoanalytical work done in New York today at well under ten dollars an hour. When this is compared to the sur-

geon's charge for his time, it seems modest enough. But when one takes into consideration the fact that the patient must pay this fee not merely once, but every day for many weeks and months, it is evident that the total cost is large. The exact amount will vary, of course, with the duration of the analysis. Taking one year as the basis of computation, eliminating all Sundays and some Saturdays, counting out at least one month's holiday in the summer and a few shorter interruptions, one is left with approximately 260 to 275 working days in the analytic year. At ten dollars per session this will then cost $2,600 to $2,750 for a year's analytical work. The total expense at higher or lower rates will vary proportionately.

Peculiarities of the Psychoanalyst's Economic Position.—The Need for Endowment Funds for the Analysis of Indigent Patients

It is true that the expense to the patient is heavy; nevertheless the psychoanalyst who sticks to his job, who does not undertake countless interrupting consultations, who works consistently day after day with the

same patients, who does not make it possible to charge each patient higher fees by giving fewer sessions per week, and who does not crowd his days with too many patients for short sessions, will never rival the income either of the successful consultant in internal medicine or of the surgeon. Indeed the psychoanalyst's position in medical economics is a rather peculiar and special one. Because a large part of his income is derived from constant and persevering work with few patients, it is relatively easy for him to become established on a modest basis. On the other hand, the amount of that income fluctuates sharply as patients start or stop. In such unusual times as these it is not a rare experience for patients who have been economically secure to be deprived of the major sources of their income in the midst of treatment, or suddenly to have to undertake heavy and unexpected financial responsibilities. It is a matter of conscience, then, for the psychoanalyst to carry that patient to the best of his ability, and not to drop him at a critical point simply because of his lack of funds. That any honest psychoanalyst is willing to do this in one or two cases

should go without saying. But when such catastrophes happen to several patients at the same time, so that several hours out of every day's work may be devoted to uncompensated labors, the very basis of the psychonalyst's economic security may be seriously threatened. He then can make himself secure only by overworking, (i.e., by taking on more patients than it is desirable for a man to carry) or by interrupting his work with some of the poorer patients to replace them with some who are more fortunately placed. In unusual times one has to adopt extraordinary methods and make unusual efforts; and most psychoanalysts are doing that at present and doing it willingly. On the other hand, there is a limit beyond which they cannot go without actually impairing the quality of the work which they do with each individual. At best the dilemma is a painful one for any conscientious physician. But until there are endowment funds for the support of the analyses of indigent patients, psychoanalysts will have to compromise as best they can between their own needs and their humanitarian impulses.

CHAPTER XVII

JUDGING THE COURSE AND OUTCOME OF AN ANALYSIS

The Need for Patience and Care in Judging.—The Data Essential for Judging

This final chapter is a plea for patience and caution in judging either the progress or the outcome of a psychoanalytic treatment. The justification for such a plea is the fact that in no other field of medicine is it so difficult for an outsider to know the essential data, without which no judgment can be valid. These facts are obvious enough: (1) Was the patient analyzed by a competent psychoanalyst for an adequate length of time? (2) What were the symptoms and difficulties which brought the patient to the psychoanalyst for treatment, and what would be the normal outcome of such a condition if untreated? (3) What would be the usual course and outcome of the psychoanalytic treatment of such a case under

favorable circumstances? (4) What specially favorable or unfavorable influences affected the progress of this particular case? (5) Finally, what was the condition of the patient at the end of the treatment in comparison with his condition when he began?

Many more facts than these are often important; but with this minimal information in hand, competent opinion would usually be possible. The difficulty arises from the fact that this data is almost never accessible, even to the interested friends and relatives. No other patients are so reticent about their symptoms, and nowhere else would the least abuse of professional confidence have such disastrous results upon the treatment itself. As a result, the psychoanalyst frequently must accept criticisms which are unfounded without being able to advance any explanations in rebuttal. Often it is impossible to take into one's confidence even the referring physician (*cf.* Ch. 14). This is a situation which the psychoanalyst deplores, but cannot change. There are many occasions when he would feel happier if he had the right to share his knowledge.

The Neurosis Which is Deliberately Hidden

A few actual experiences, which are in no way exceptional, can best give point to this plea. A frequent difficulty arises from the fact that neurotic problems may be completely dissimulated. Far more often than is generally realized, patients may succeed for years in fooling their friends and families into looking upon them as people of peculiar stability and poise. They may carry responsibilities well. As far as the rest of the world can know, they may appear happy and successful. But all the while, and notwithstanding this courageous façade of health, they may constantly be suffering from neurotic symptoms which they never acknowledge. When such persons finally come to psychoanalysis these hidden symptoms may quickly be exposed, in which case the patient soon looks and feels worse than when he began. At this the family and the referring physician will naturally feel anxious; and the impression may become general that the analysis is making the patient worse. Actually, of course, this uncovering of the underlying neurotic problems is a first essential step, without which no healing can occur. This is one of the situations

in which it is wise to give psychoanalytic patients a reasonable amount of privacy and seclusion from their daily contacts, and in which the well-meant solicitude of loyal and understanding friends may be an unnecessary strain.

Example of the Masked Neurosis

A young business man is an example of such a situation. He was a man of exceptional ability who early in life had achieved unusual success. In addition to that, he had carried the responsibilities of two households, and managed the affairs of a large family which looked up to him as to a figure of unshakable strength. No one but his wife had the slightest suspicion that he was troubled by an array of phobias and by a psychosexual problem which brought him at times to the verge of suicide. For the sake of the many people who were dependent on his strength, this patient had kept his sickness a secret, and kept secret also the fact that he was being psychoanalyzed. Had anyone known this, however, within a few weeks after its inception a cry would have been raised that under the influence of the psychoanalysis the

patient was falling seriously sick; because by that time all his acknowledged symptoms were in full bloom, and in addition a great many others had come to light which theretofore had been hidden. Fortunately in this case there was nobody who could interfere, with the result that the patient had an opportunity to work through this symptomatic outburst to reach lasting health.

The Patient Who Does Not Coöperate

Equally difficult for the outsider to judge fairly is the case of the patient who comes to analysis and attends each session faithfully, but never does a stroke of analytic work. Sometimes he comes and says only selected things, consistently refusing on the basis of one excuse or another to follow the method of free association. In the end, after a certain conscientious period of effort, the psychoanalyst will discontinue such a treatment. If the patient is seriously sick, however, the psychoanalyst may hang on doggedly, trying by every device at his command to break through the patient's defenses, because he knows that unless he succeeds in doing so the patient will remain sick

indefinitely. If he fails, the outsider will think, "What a racket this is, all that time and money for nothing"; and the defeated psychoanalyst is not free to explain that the patient may have come for six months or more, and yet in that entire period may have done barely six days of honest analytical work.

The Race Against Time

There is another type of case in which the treatment may best be regarded as a race against time, that is, a race against an illness which has already acquired a great deal of momentum. For instance, certain sudden emotional disorders which lead at times to serious mental illness can sometimes be arrested by psychoanalytic interference. At some point in the preliminary period of nervous instability the family becomes anxious and impatient, or else things threaten to take a turn for the worse. Out of desperation and anxiety the patient is brought to the psychoanalyst. If he is daring enough to undertake the treatment of such a patient he begins a race which it is difficult to win. Occasionally he will succeed in cutting short the attack and in returning the

patient to normality without his having to go through the entire cycle of illness. More frequently, however, before he can get the analysis fairly launched, the patient will have become sufficiently disturbed to require either hospitalization or at least a temporary interruption of the analysis—an interruption which will have to continue until the patient begins the long, slow stages of convalescence.

Example of the Race Against Time

An example of this type of experience is the case of a man in his middle forties, who had been subject to recurrent periods of severe emotional illness for nearly twenty-five years. In the incipient stages of a fresh attack, this patient was placed under treatment in the hands of an able colleague. In a short time, however, despite this analytic interference, the patient had to be hospitalized for a few weeks. When this happened some of his closest friends and relatives became much alarmed, and accused the psychoanalyst of having produced the illness. Overlooking the fact that this illness had appeared in this patient's life many times before psychoanalysis had ever been con-

templated, they tried unsuccessfully to influence the patient's wife to interrupt the treatment. After a period of a few weeks of hospitalization, however, the patient improved sufficiently to enable him to return to his analysis, at first while living in the hospital, and then from his own home. It was soon found that the analytical work which had been done before the more severe upset related itself immediately to that which was being done during the convalescence; and the final outcome of the two together was a return to uninterrupted health. In this case it was only the wife's firm confidence in the psychoanalyst that prevented a premature interruption of the treatment.

The Forlorn Hope

Perhaps more difficult to evaluate than any of these, however, is the problem of the forlorn hope. There are desperate illnesses in the field of psychiatry, just as there are in other medical fields. That is to say, there are illnesses which are so severe that the patient almost never makes a recovery, or at best remains for the rest of his days a crippled personality. Sometimes such conditions develop out of seemingly

innocent and insignificant neurotic disturbances; and a patient may be brought to psychoanalysis for troubles which the family and the family physician look upon as trivial, although the patient may actually be standing on the brink of a most serious and lasting mental illness. Here the diagnostic keenness of the psychoanalyst is of vital importance; and it is here that the adequacy of his fundamental psychiatric training is put to the test. If such a process has not gained too much headway, the psychoanalyst, after frank discussion of the dangers with some responsible representative of the family, may resolve to attempt to check the progress of the disease. Under such circumstances it is rare that anyone but this official representative of the family realizes that the psychoanalyst is undertaking a forlorn hope and that his chances of success are slight. Yet if no analyst is willing to risk the effort, the patient may be deprived of his only chance of escaping serious and perhaps permanent sickness. It is in just such situations that those who are on the inside keep their knowledge to themselves; so that in the event of failure, it looks to the rest of the world as though a slightly

nervous person has been driven into an asylum by psychoanalytic intervention.

For instance, a severe case of paranoia was already well-developed before the patient was brought to any psychiatrist. Nevertheless to the casual observer the patient still seemed merely "a little nervous". At the insistence of the family the patient was subjected to a cautious psychoanalytic investigation, which was abruptly interrupted by the family after only a few weeks. Two years later, when the patient broke down completely and required permanent hospitalization, the illness was blamed by many outsiders on the few weeks of cautious psychoanalytic searching. Psychoanalysis cannot claim to be that potent, whether for good or for evil.

The Disgruntled Patient

A less subtle source of trouble for the psychoanalyst may be the patient who comes with impossible hopes as to what analysis should do for him, cravings which he may never relinquish despite the fact that they are not attainable by anything short of magic. Unless the analysis succeeds in uncovering and resolving these

phantasies, such a patient usually goes away disgruntled, even when he may have been relieved of serious symptoms. For instance, a young artist in his early thirties came to a psychoanalyst for the treatment of a neurosis which had had its symptomatic onset before he was fifteen years of age. He was a man of outstanding ability, who had on several occasions been offered important positions in the world of art. On each occasion, however, his acute anxiety states, his fantastic compulsions, his neurotic seclusiveness and hostility, and his disordered psychosexual life, prevented his realizing his ambitions. When he came to the psychoanalyst he had been unable to work for nearly a year, because of a purely imaginary "hysterical" paralysis of one of his arms. As a result he and his family were on the verge of starvation. For many months he was treated without charge; and during the course of that work he was able to resume his craft. He secured a good position in commercial art, and he could feed and support himself and his children, and began to pay a moderate analytic fee. The larger part of his neurotic symptoms were reduced to negligible severity, although they

were not completely removed. Indeed in the end the patient acknowledged that he clung to the symptoms which remained chiefly as an excuse for not pursuing again his earlier ambitions. Nevertheless, and in spite of his obvious improvement, after an unavoidable and premature interruption of his analysis this patient became hostile. Because the psychoanalyst had not turned time back twenty years to make him again the infant prodigy which he once had been, he inveighed against psychoanalysis and the psychoanalyst. In his attacks he stressed only the large amount of time which he had contributed to his treatment. Furthermore, as evidence of his unimproved condition he pointed to the fact that he was still unable to realize his earlier ambitions. Naturally he did not mention the severe and crippling symptoms which had irradiated throughout his entire life, throwing him out of work and rendering him helpless and penniless, and of which to all intents and purposes he had been relieved by the analysis. His hearers heard only what he chose to tell them, and misjudged the value of his analytic experience accordingly.

With the patient or his family hedging his illness around with secrecy and deception, it is small wonder that the world at large gazes upon the progress of an analysis and its outcome with skepticism and misgivings. Nevertheless it is fair to claim for the psychoanalyst the right to be judged only in the light of full information.

The Position of the Family, and the Family Physician. — Inevitable Symptomatic Exacerbations During Treatment

It has already been seen (Chapter 14) that the family physician can rarely be taken into the analyst's confidence. For the family as well there are special difficulties. Often enough the relatives may be a focal point for the patient's neurosis, stirring it into symptomatic activity long after it has become inert in other situations. That is one reason why so many patients can maintain a pretense of health before the world at large long after their families are well aware of their illnesses; and it is also the reason why such patients may show marked improvement elsewhere, and yet continue for a long time to exhibit all of their old difficulties

when with the family. This is hardly likely to excite in the family much confidence in the therapeutic value of the analysis; and is likely to give them a one-sided picture of the patient's progress. Furthermore, despite adequate warnings, it is hard for family and friends to believe that in the treatment of a neurosis, by whatever method one uses, a patient must get worse before he gets better. Yet this occurs inevitably, because every human being shields himself from that which is neurotic in his nature just as fully as he possibly can; so that every patient must first go through the painful and distressing experience of facing unsuspected depths of illness before he even begins to turn towards health. This initial, and indeed recurrent, intensification of symptoms may be serious enough to cause grave concern to family and friends and medical advisors; yet it is something for which everyone who faces an analysis must be prepared.

Psychotic Episodes in Psychotic Patients

At times patients who have had full-blown psychotic episodes should be treated psychoanalytically during their intervals of health.

In all such situations some responsible representative of the family must from the first be made to realize that such episodes may arise to disturb the analytic work at almost any time, and sometimes with little warning; and that it is only after several such episodes have been resolved analytically that the patient's health will become in any degree secure. Without such forewarning, misunderstandings are sure to arise which will lead to premature interruption of the work.

The Psychoanalyst as Judge of His Own Case

Who, then, is in a position to gauge the progress of an analysis? Unfortunately there is no one but the psychoanalyst himself, and in the later stages of work the patient as well. During the course of the analysis no one else can estimate whether an apparent improvement is soundly based, or a mere effort to cover difficulties and escape into a pretense of health. No one else is in a position to judge whether an exacerbation of symptoms is a portent of disaster or a necessary, if painful, step towards recovery. And if the family has not sufficient

confidence in the psychoanalyst's integrity and ability to trust him with this decision, they would be better advised not to entrust the patient to him at all.

The Final Test of Health

After an analysis is really over, however, it is fair to appeal to a wider court in evaluating the psychoanalytic work; and provided that the judges have any true knowledge of why the patient came to an analysis, it is fair to measure its results in terms of the patient's happiness and peace, his pleasure in activity, his freedom from disturbing states of depression, anxiety, guilt, fear, or jealousy, and more particularly his freedom from the special neurotic symptoms which may have brought him to analysis.

The Variety of Problems Treated by Psychoanalysis

That many analyses fail to achieve all of this goes without saying. To anticipate the same measure of success in such a heterogeneous lot of illnesses as comes to the hands of the psychoanalyst is to demand something that no

therapeutic method can claim, namely, the ability to treat a variety of illnesses with equal success in each. It is forgotten that under the cover of some such euphemistic term as a "nervous breakdown" the psychoanalyst faces problems that may include drug addictions, the perversions, every known form of psychoneurosis, and incipient insanities of various kinds. It is not for the lay public to attempt to estimate the therapeutic value of psychoanalysis in the face of complexities such as these. It is not even a task for the non-psychiatric members of the medical profession. In the end the psychoanalyst, like everyone else, can be adequately tried only by a jury of his peers—that is, a jury composed of men who know as much about psychiatry and psychoanalysis as he does himself.

The Adaptation to the Existing Life Situation

Certainly it is not an analytic goal to alter fundamentally the life situation of every patient. Rather does the psychoanalyst hope to make it possible for the patient to find health within the framework of the life which he has

already created. This means that by and large the psychoanalyst prefers to leave marriage and work, etc., unaltered. On the other hand, as was explained in Chapter 15, this aim must always be secondary to the patient's health. Where a life has been built completely under the influence of neurotic mechanisms, nothing short of radical alterations may suffice to make health possible. In such situations the analysis becomes a surgical instrument, the psychoanalyst needs a surgeon's courage, and the patient the ability to endure pain. It takes a good surgeon to know when not to operate —and a good psychoanalyst to know when to leave things alone. But the final criterion of success is the health of the patient and not what has had to be removed.

Some Reasons for Failure

For his own guidance the psychoanalyst could summarize as follows some typical causes for analytic defeats:

1.) Those which are due to faulty technique, and faulty diagnosis, etc.; which can be reduced to a minimum by turning only to properly trained men.

2.) Analyses which fail for external reasons, although they have been soundly conducted:

(a) Because they have been prematurely interrupted by unavoidable external circumstances.

(b) Because they have been prematurely interrupted because of the impatient interference of those who influence the patient. These can be avoided where it is possible to give proper instruction to the responsible members of the family as to what to expect; and where the family is sufficiently stable to hold to the course that is agreed upon.

3.) Soundly conducted analyses which fail because of forces inherent in the illness which is being treated:

(a) Where the psychoanalyst has made a legitimate but unsuccessful effort to save a patient who was already desperately ill—i.e., the "forlorn hope".

(b) Those which fail temporarily because in a race to stave off a process which has already gained too much momentum, the analysis is beaten. Such temporary failures may in the end

turn out to be brilliant successes, if in a later and less stormy phase of the illness the analysis is resumed.

4.) Analyses which fail because of forces peculiar to particular cases:

(a) Where a patient who suffers from an otherwise curable neurosis cannot be induced by the psychoanalyst to undergo those essential emotional deprivations without which no real analysis is possible (*cf.* Chapter 12).

(b) Those which fail because the life situation of a patient is so unalterably unfortunate that life itself can offer nothing better to the patient than the retreat afforded by the neurosis.

(The first group is sometimes represented by patients who have been spoiled by great wealth; and the second group by certain sufferers from great poverty. Subtler factors than these, however, can also play a determining role.)

5.) Analyses which fail because the patient cannot be induced to abandon deliberate plans to block the treatment:

(a) In which the patient comes to the analysis for months but can never be launched in the free production of his material.

(b) Where patients enter analysis reluctantly, under pressure from some external compulsion rather than because of an acknowledged internal need. Such patients often are firmly and unalterably resolved to withhold essential data either as a deliberate effort to thwart the psychoanalyst and thus to take revenge on those who forced the analysis on them, or else to protect someone else.

(c) Where the patient has a secret but conscious determination not to get well, e.g., because he feels that to recover would involve a tacit admission that the whole illness was psychological or from within, instead of being physical or due to external forces. To blame the body or the outside world is always a temptation to the patient who looks upon his illness as a sign of shameful weakness.

The list could be extended greatly to include many technical factors, until the reader in confusion would begin to wonder how it happens that psychoanalysis ever succeeds. One may offer assurances on this score, however, and couple them with the comment that one hears much less about psychoanalytic successes than of failures. Partly this is because the healed patient goes his way quietly and gratefully, often with few people knowing the nature or extent of his previous difficulties, and even fewer knowing that he had ever been under psychoanalytic treatment.

The Right of Consultation

Although the foregoing discussion sounds like a plea never to criticize an analysis because the facts are not accessible to the critic, it is nonetheless true that mistakes may occur in analyses as in any other form of medical therapy, and that there must then be some acceptable form of intervention. Granting that before undertaking the analysis it is essential to have the fullest possible assurance as to the integrity and ability of the psychoanalyst who is chosen, and that thereafter it is wise to leave

things in his hands, nevertheless it must be acknowledged that situations will arise in which the inalienable right of a patient or of the family to ask for a consultation should be exercised. The only question is how to do this in such a way that the further therapeutic usefulness of the psychoanalyst to the patient should not be impaired. A simple course can be recommended:

(a) If this was not done at the beginning, it is essential to ascertain from a psychoanalytic society whether the particular physician is an adequately trained psychoanalyst.

(b) The next step would be to go directly to the psychoanalyst himself with all of one's doubts and questions.

(c) If this does not allay the anxiety that has arisen, one must then ask for a consultation in which preferably there should be both another psychoanalyst and a psychiatrist who is not a psychoanalyst. In arranging such a consultation it is best to work out with the psychoanalyst how and when the patient should be examined by the consultants. In fact, unless there is grave and reasonable doubt as to the integrity or competence of the man in

question, it will usually be well to defer such an examination of the patient until after a preliminary conference between the psychoanalyst, the consultants, and the representatives of the patient.

One cannot be sure that taking such steps will always settle the disquieting issues; but it is as fair and clear a way as is available. Fortunately such procedures are only rarely and in exceptional cases necessary.

APPENDIX I

OUTLINE OF WHAT IS GENERALLY ACCEPTED AS CONSTITUTING SOUND PSYCHOANALYTIC PROCEDURE AND ETHICS

I. THE PREPARATION OF THE PATIENT

1. Since many patients come to analysis with little understanding of what lies ahead of them, a frank description of the inevitable features of the experience must be given either to the patient himself or to his responsible advisor. This means that the patient should be prepared (a) for a treatment that may last anywhere from one to three years, and occasionally even more (*cf.* Chapter 2); (b) for daily sessions, five or six times a week, each lasting approximately an hour (*cf.* Chapter 3); (c) for an almost unbroken continuity of the work, with a minimum of interruptions either by vacations or by other duties (*cf.* Chapter 3).

2. Furthermore, since patients naturally come to analysis hoping for steady gains and a prompt relief of symptoms, they must be forewarned against the difficult but salutary exacerbations of symptoms which occur during analysis (*cf.* Chapter 17).

3. Finally, since not all patients will profit by analysis, and since it is not always possible ahead of time to foresee how an individual case will respond, a prospective patient should understand that an analysis often begins as a trial (*cf.* Chapter 1); and that it may only be after some weeks that a final decision as to its advisability can be reached.

II. FINANCIAL ARRANGEMENTS

1. The patient should budget frankly with the analyst for at least two years of continuous analytic work.

(a) Therefore he should not agree to pay a larger fee than will allow the resources which are available for his treatment to last throughout its course.

(b) If a patient whose funds are limited is informed by the analyst he has consulted that he is already carrying as many patients at reduced rates as he can afford, he should not ask the analyst to reduce either the frequency or the duration of the sessions (Chapter 3).

If the analyst in question cannot give the patient a full analytic schedule at a reduced fee, the patient should ask to be referred to another analyst. This does not mean that the other analyst will be inferior, but only that he happens at that moment to have an opening in his schedule which allows him to take on a new patient at a reduced fee.

(c) The patient should be warned against any offer on the part of the analyst to reduce either the frequency or the duration of the analytic sessions. This practice, which results in the crowding of more patients into each day and week, is not sound psychoanalytic procedure and is likely to be motivated chiefly by mercenary considerations.

(d) The patient must be prepared to look upon his agreement with the analyst as an unwritten contract in which he makes himself financially responsible for the time allotted to him whether he comes to his session or not, until either he or the analyst discontinues the treatment (Chapter 16).

(e) If a patient unexpectedly exhausts his funds in the midst of his analysis, he will find that the analyst's attitude will be governed by two major considerations: (1) what effect it will have on the analysis to carry it on free of charge, and (2) what the analyst is able to do,

in the light of sacrifices he may already be making for other patients. The plan of procedure will be worked out fully in the analysis, and if an interruption of the treatment should prove to be necessary it will be done gradually and only after adequate preparation of the patient.

III. THE CHOICE OF ANALYST AND THE CHOICE OF PATIENT

1. The analyst should be a person who as an individual is practically a stranger to the patient, and furthermore a figure about whose personal life the patient is not likely to learn very much. Therefore to an analyst who is a friend or relative, or even an intimate friend of an intimate friend or relative, the patient should apply only for guidance to some other psychoanalyst. (Chapters 5 & 11)

2. Under ordinary circumstances the analyst will accept only patients who come essentially of their own volition. (Chapter 8, Sec. 1) Furthermore he will rarely accept simultaneously two brothers or two sisters, a brother and a sister, a man and his wife, or two intimate friends. (Chapters 5 & 15)

3. To have a moral right to use the name, the analyst should be a member of an accredited psychoanalytic society, and through

it of the International Psychoanalytic Society. (Chapter 9, Sec. 1) The patient may ascertain this by writing to the secretary of the nearest psychoanalytic society. (Appendix II).

4. Most particularly must the patient be warned against the "wandering analyst" who spends his time in moving from short stays in one center to short stays in another, leaving behind him a trail of remunerative but fragmentary and destructive pseudo-analyses. (*cf.* Chapter 3)

IV. THE CONDUCT OF THE ANALYSIS

1. In the conduct of the analysis the patient will be assisted by every means at the analyst's command to achieve the capacity to produce free associations, in the form of free and unguided, easily flowing thoughts, feelings, images and ideas. (Chapter 4). With rare exceptions, and for the greater part of most analysis, this will be greatly assisted by the use of the analytic couch. (Chapter 5). Obviously the bringing of written records, whether of dreams or of experiences, and the use of direct questions, will be resorted to sparingly, because both tend to limit the patient's production of free and spontaneous material. (Chapters 4 & 5)

2. For this and other reasons, throughout the analysis the analyst will preserve his "analytic incognito" as completely as is humanly possible, making no exhibition of his interests, tastes, pets, family concerns, possessions, scientific achievements, and the like. Social contacts outside the analysis between the patient and the analyst will be avoided scrupulously. (Chapters 5 & 11)

APPENDIX II

LIST OF ACCREDITED PSYCHOANALYTIC SOCIETIES

* The Boston Psychoanalytic Society, 520 Commonwealth Ave., Boston, Mass.
* The Chicago Institute for Psychoanalysis, 43 East Ohio Street, Chicago, Ill.
* The New York Psychoanalytic Institute, 324 West 86th Street, New York City.
* The Washington-Baltimore Psychoanalytic Society, 2440 16th St., N. W., Washington, D. C.
* British Psychoanalytic Society, 81 Harley St., London, W.1, England.
* Deutsche Psychoanalytische Gesellschaft, Lessingstrasse 1, Berlin N.W. 87, Germany.

Indian Psychoanalytic Society, 14 Parsibagan Lane, Calcutta, India.

* Chewra Psychoanalytith b' Erez Israel, Tablye, Jerusalem.

Conduct training institutes.

* Magyarorszagi Pszichoanalitikai Egyesulet, Klotilducca 4, Budapest V, Hungary.
* Nederlandsche Vereeniging voor Psychoanalyse, Schiedamsche Singel 235, Rotterdam, Holland.

Vereeniging van Psychoanalytici in Nederland, Wassenaarsche weg 39, Haag, Holland.

* Societé Psychanalytique de Paris, 11 Quai aux Fleurs, Paris IV, France.

Russische Psychoanalytische Vereinigung, Rjewski Per 8, W. 14, Moscow, U.S.S.R.

Schweizerische Gesellschaft für Psychoanalyse, Gartenstrasse 65, Basel, Switzerland.

Sendai Psycho-Analytic Society, The Psychiatric, The Tohoku Imperial University, Sendai, Japan.

Tokyo Psycho-Analytic Society, 825, Motoshiba, Oimachi, Tokyo, Japan.

* Wiener Psychoanalytische Vereinigung, Bergasse, 19, Wien, IX, Austria.

Scattered in many countries, and in various cities of the United States, are isolated analysts or groups too small for formal organization. Such men are members either of the societies in which they received their psychoanalytic training, or else of the societies which

* Conduct training institutes.

are nearest to the cities in which they live. Information as to the whereabouts of the nearest analyst can be secured by writing to the secretary of the nearest psychoanalytic society.